The Modern Hospital

JANUARY 1957

PLAYROOM, PEDIATRICS DEPARTMENT, FAIRVIEW PARK HOSPITAL, CLEVELAND (Page 77)

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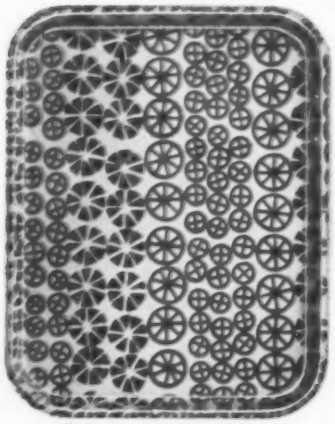

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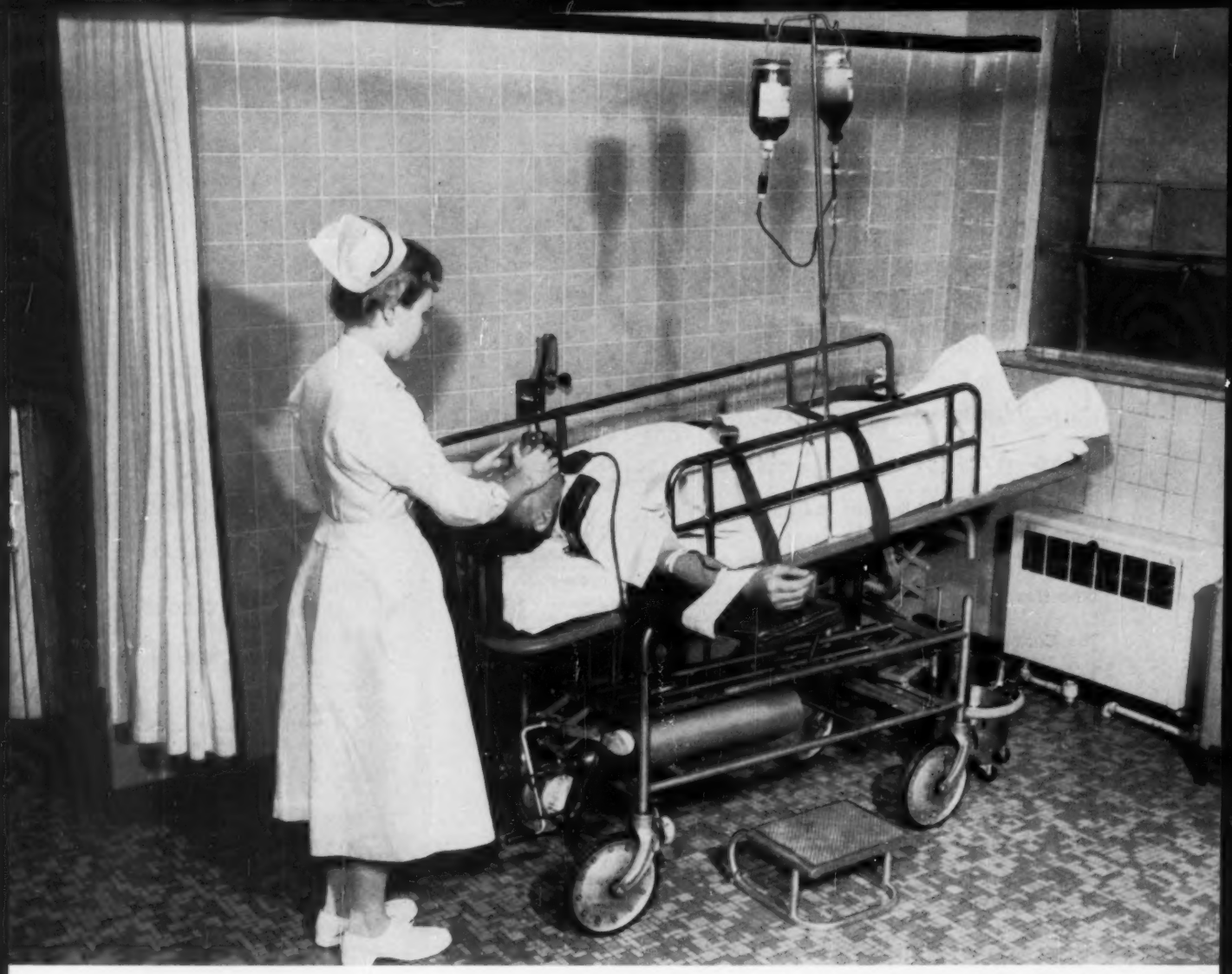

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The Modern Hospital

VOLUME 88, NO. 1

JANUARY 1957

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AMONG THE AUTHORS


Bert H. Cohn

Into the proverbial cocked hat is just about where **Bert H. Cohn** would knock most theories about nursing homes. He startled some members of the American Association for Hospital Planning at its meeting in September by suggesting that nursing homes be constructed according to the actual wants and needs of the persons who will inhabit them. On page 65, Mr. Cohn, who operates nursing homes in Benton and Okawville, Ill., elaborates on his own practical nursing home experience. The years have been interesting for Mr. Cohn, who started out with his brother-in-law in the field of intravenous therapy. Later he learned about mass food preparation when he spent several years in restaurant and hotel work. Mr. Cohn currently is executive secretary of the Illinois Commission for Aging and Aged, a post to which he was appointed by the governor in 1955.


Nathan Bushnell III

High school students in Franklin County, Virginia, can get a running start on an education in at least five areas of hospital procedure, thanks to a program set up at Franklin Memorial Hospital, Rocky Mount. **Nathan Bushnell III,** the administrator, describes the program on page 53. Lasting the length of a school year, and concurrent with the students' regular high school program, the course includes 21 lectures of an introductory nature plus instruction in five specialized areas. Mr. Bushnell is a graduate of the school of hospital administration, Medical College of Virginia.


Viola R. Pinanski

A new volunteer in a hospital can be like an "innocent abroad," if she doesn't know what to do and how or when to do it. This is only one reason for carefully planning and supervising work of volunteers. On page 86, **Viola R. Pinanski,** former chairman of the American Hospital Association's committee on auxiliaries, points out the importance of planning in volunteer work and discusses recent trends in kinds of services performed by auxiliaries. Mrs. Pinanski is no stranger to the hospital scene; she's been a volunteer worker since 1921 and has been president of the women's auxiliary at Beth Israel Hospital, Boston.


Joe J. Jordan


Hanford Yang

Joe J. Jordan and **Hanford Yang** are the winners of an architectural competition for the design of a home for the aged (page 62) sponsored by the National Committee on the Aging and the National Social Welfare Assembly. Mr Jordan, a project designer with the office of Vincent G. Kling A.I.A., Philadelphia, was the top architectural student in his 1949 graduating class at the University of Illinois. He toured Denmark in 1954 under sponsorship of the state department to study housing and city planning. While there he collaborated on a comprehensive plan for the town of Frederiksvaerk. Currently he is working on a redevelopment plan for downtown Philadelphia. Mr. Yang, a native of Shanghai, China, and son of a former governor of Kweichow province, came to this country in 1948. He is presently at the Massachusetts Institute of Technology graduate school of architecture.

READER OPINION

"How Not to Build" Misleads

Sirs:

Reading the article by John French Allen, entitled "How Not to Build a Hospital," a few thoughts pass through my mind which I should like to convey to you.

At the outset let me state how gratifying it is to know that magazines publish negative criticism so that others may benefit by hard-learned lessons. It indicates a forthright and fearless approach to help find the real solutions to real problems. I feel you deserve much praise for having accepted the article, and Mr. Allen is to be commended for his willingness to go on record in such a delicate matter. The lesson we can learn is that "the thing itself" is more important than the people involved.

The critique itself, however, is in some aspects misleading and I should like to offer some views which I hope will be accepted with the same spirit of good will which produced Mr. Allen's article.

I should like to state that I know nothing about this hospital except what I read in Mr. Allen's article and in an article published by the *Architectural Forum* of February 1951.

"Architectural beauty without function." My views are not to be taken as a defense for architects or architecture but rather as an attempt to define what to expect of architecture.

One cannot expect the architect to develop a program for the building, without statements in detail as to particular requirements. It is wrong to ask the architect how many patients a nurse can care for or whether a hospital should have a laundry.

This leads me to my first point. It is the administrator's duty to advise the board in such matters so that the board can give intelligent orders to the architect. There is no mention of such an administrator in the entire article. The only time we are told about an administrator is after the hospital failed, and a new administrator was engaged. What I should like to point out is the need for an administrator before the physical hospital plant exists. It is one thing to design a floor for 16 patients, knowing how many nurses are needed and how much it is going to cost, and quite another to be surprised when the pay checks have to be written. The article fails to point either way.

These relations have nothing to do with the function as related to beauty. An economical building attests to the quality of planning but not to functional architecture. I think that the building is functionally a huge success because the physical environment provided for the patients is sensitive to their spiritual needs for recovery. What could be more important to the healing of the sick than the joy of life and air, and the recognition of the dignity of man? These relations have been fulfilled to an extreme degree and with a rare sensitivity. Therefore we all say that the hospital is "beautiful."

"The balcony." It is a very regrettable situation indeed, if an insurance company is going to dictate whether it is good to have a balcony for the rehabilitation of a patient or not. Nor is the architect to decide this issue; but the medical board, who sets the premise for healing in the particular

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institution, would deliberate the balconies as much as any therapy room. The insurance company then will have to deliberate how to solve their problem if the doctors feel that a balcony is beneficial.

Concerning Mr. Mendelsohn personally, the article gives the impression that Mr. Mendelsohn never designed a hospital before Maimonides. Architect Mendelsohn designed the University Hospital Center, and the Haifa Hospital in Israel: see *Architectural Forum*, February 1951. He is therefore not a stranger to hospital design.

The financial accounting as described in the article seems a real eye-opener for future planning boards. Of special importance was the concept of the relationship of Maimonides to Mount Zion Hospital which turned from economic aid to economic nightmare. However, I find in the typical accounting example for May, June and July, that bills dating back to the previous September, accumulated bills for steam, laundry and services to Mount Zion, as well as advances from the Federation of Jewish Charities, were added to expenses incurred during the three months. This does not seem a fair accounting method to me.

Concerning the list of total annual deficits it would be fair to mention that every hospital expects a deficit during the first year and provides funds in advance for this purpose. The article also fails to point out the percentage of occupancy during the total time of operation, and fails to state the average length of stay per patient to determine whether the $115 deficit per patient is high or low. Also the average loss of $2.49 per patient per day should be related to percentage of occupancy and the cost of $17.79 should be related to similar institutions to have more meaning.

I should also like to point out that if some of the difficulties at Maimonides are due to circulation difficulties or mechanical inadequacies, they should be carefully described. It seems to me, they are easiest to rectify, in any future hospital planning.

It is with much gratitude to you and your magazine that I am writing these notes on the Maimonides critique. And it is with sincere hope that the prayer of Maimonides so aptly quoted in the article will guide us all in the self-assumed right of criticism.

Eric J. Pick

New York City

EDITOR'S QUERY

Why couldn't the balconies have been both beautiful *and* safe? The fact that they served a rehabilitative function does not seem to shift the entire burden of responsibility for their safety from the architect to the medical staff.—ED.

ARCHITECT'S REPLY

It seems that words do not always fully describe facts and thoughts. I should just like to mention that reading the article it never occurred to me that the balconies as built were unsafe mechanically, that is, the rail not at a proper height, or nonslip floors. I somehow got the idea that they were objectionable as such. If the balconies were not properly designed to meet a reasonable or prescribed standard of safety, then I fully agree that the architect has not carried out his responsibilities.

Eric J. Pick

We're No Help

Sirs:

In the Small Hospital Questions section of the November issue of The MODERN HOSPITAL, I don't think you

gave "R.C.S." much help regarding the handling of late charges to patients. Here is the system that is being used with success in many hospitals.

As soon as a patient has been discharged by the attending physician, or even if the discharge has been made known to the nurse pending a final visit, it is reported to the cashier on a form entitled "Notice of Discharge." This report indicates the probable hour of discharge and lists the "extra" services rendered during the previous 24 hours. No patient may be discharged without this report's being submitted at least an hour beforehand. The majority are sent to the office before 8 o'clock in the morning covering most of that day's discharges.

This system gives the office an opportunity to (1) check on postings not yet made to date and (2) type an itemized statement of the patient's account before he goes home.

Bentley Frederick
Little Traverse Hospital
Petoskey, Mich.

The Cost of Heating

Sirs:

The following are comments on the article, "The Cost of Heating Is Going Up In Smoke," on page 130 of the September issue of The MODERN HOSPITAL.

BOILER CAPACITY

1. Without going into any elaborate calculation on boiler capacity I would estimate the maximum load on a hospital of this size (2,100,000 cu. ft.) as 350 h.p. The actual maximum load, according to the article, measured at 5 degrees above zero was 280 h.p. which at −10° would make it somewhat over 300 h.p.

2. Two 200 h.p. boilers would have the necessary capacity to meet the requirement that they handle the load at normal rating, plus giving complete standby protection, since one boiler operating at 150 per cent of rating would give the required capacity of 300 h.p. Actually based on average winter temperatures, one boiler only would need be on the line at any time, allowing the operator to rotate boilers for cleaning and maintenance.

3. Allowance for 100 per cent expansion of the hospital in the future would only mean adding one more 200 h.p. boiler, giving them a total of 600 h.p.

4. Personally I think this is a better solution than the one suggested in the article of three 100 h.p. boilers, two high pressure and one low pressure. The initial cost of installing three boilers and accessories against two would be greater. In the future another low pressure boiler would have to be installed as well as at least one high pressure boiler, making a minimum of five boilers as against three. This would take more cubage.

5. Ventilation of a boiler room in a basement is a necessity and certainly insulation of the ceiling over the boiler room and equipment room is required, as we have found out in the past.

WATER CAPACITY

1. The laundry water was heated by an instantaneous heater which we never use, because there is no storage capacity to draw on.

2. The domestic hot water was supplied from two 1900 gallon storage heaters which the article claimed was adequate for both laundry and domestic use. A rough check based on bed capacity indicates that this is true.

3. Their solution of cross-connecting these two and eliminating the instantaneous heater is good.

4. The fluctuation in water pressure was the result of the undersized softener and the solution of putting a surge tank in the line is an expedient, but the answer obviously is a correctly sized softener.

RADIATION

1. The heating system was steam with individual room thermostats (at $100 plus per room). The use of a hot water heating system eliminates the cost of the thermostats and provides control by varying water temperature with outside temperature. This is our standard practice.

2. I agree with the writer on normal sized windows, which, of course, should be tight. These all-glass rooms are an abomination to the heating engineer; not only do they increase the radiation terrifically, but where in thunder do you put it? Whatever is done, after time consuming research, is definitely much more expensive.

3. I do not agree that double insulating glass should be used or that the building walls should be insulated to the extent that the writer outlined. I do not feel that the savings in cost of radiation or of operation would justify the added expense.

O. M. Schneider
Schmidt, Garden & Erikson
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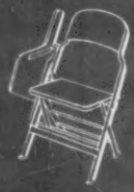
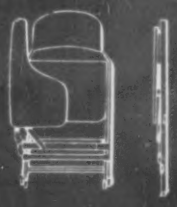


2. Tablet arm swings down permitting use as regular chair.



3. Chair folds in normal way and tablet arm swings over flat against seat. Folds to 3" thick.

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The Ever Growing Bed

Much like our cars, patient beds continue to get longer. Is this increase really justified? To be sure, statistics do show the human race increasing in height.

Some of the older beds still in hospital use are no more than 6 feet 9 inches in length. This is an inch longer than is the average hotel bed. Not so long ago, for hospital planning, 7 feet was assumed the standard for patient beds. The latest models now substantially exceed this figure.

For most areas in a hospital the unit of effective measure is, in reality, the length of the patient's bed. For every increment to the bed length, just so much should patient rooms, ward corridors, and many other areas increase in width. This swelling of the building adds substantially to the over-all cost. Bays must be wider, beams heavier, slabs thicker, columns larger, and service runs longer. On top of this is a bit more mileage for the nurses.

Certain special items are affected even more adversely. Take elevators, for example. It now becomes advisable to specify only the larger of the two standard platform sizes, namely the 5 feet 8 inches by 8 feet 4 inches in place of the 5 feet 4 inches by 8 feet formerly considered adequate. Actually the increase in well and cab size is the smallest part of this burden. The shift involves a step to the next larger machine size, and this is a considerable item of additional cost.

Finally, there is the problem presented to the existing hospitals that find themselves in need of new beds. Many buy them without suspecting the dilemma that delivery will bring. For some, wards must be reorganized or beds eliminated. Many hospitals have elevators below present standards in size, and they just will not take the new beds.

The problem of patient beds is peculiarly an American problem. Whereas European patient beds are an engineered piece of medical apparatus, American beds are, first of all, an extension of home environment transported to the sickroom. This is the first handicap that faces a manufacturer if he wants to produce a scientifically designed bed. One suspects, however, that the increase in length is largely acceptance of the philosophy of bigger and better. Apparently, mattresses have been pretty well standardized at 6 feet 6 inches. Add an inch clearance at either end, which is the clearance in some beds, either head or foot, and add another inch at each end for the head and foot board, which is the actual thickness of some of the newer models. That would give a total of 6 feet 10 inches. What are the extra 6 or 7 inches for? The cost added to the bed is a trifle as compared to the added financial burden on a new hospital if it makes the proper adjustment in size.

As for our crop of 7 foot basketball players who occasionally get hospitalized, they are still a minority and should not penalize an entire hospital structure. Surely, a capable product designer should be able to find a simple solution for occasionally expanding or adding to the effective mattress length of a standard bed.

Assuming now that 6 feet 10 inches is within the realm of probability, one would like to pose another question. Quite a few hospitals cater only to women, maternity and gynecology patients. In addition, many wards have only female patients. Why should they be burdened with these oversized beds? Certainly, for women, a bed length of 6 feet 6 inches should be ample. Where women only are concerned and especially where rooms are small and cramped, smaller beds would be a boon.

It must be admitted that the bed manufacturers are not in an enviable position. A truly functional bed would no doubt be unsalable. Perhaps the best we can do for the moment is to make everyone conscious of the problem.—FREDERICK E. MARKUS *of Markus and Nocka, architects, Boston.*

Pets' Blue Cross

A Los Angeles company, operating on the theory that illness of a cat or dog can be as expensive, if not more so, than it is for a human being, is offering for $20 a year, "complete medical-surgical-hospital protection" for pets. This prepaid veterinary care, following in the footsteps of Blue Cross-Blue Shield, is offered by Pet Health Plan, Inc. The plan has one drawback—no maternity benefits.

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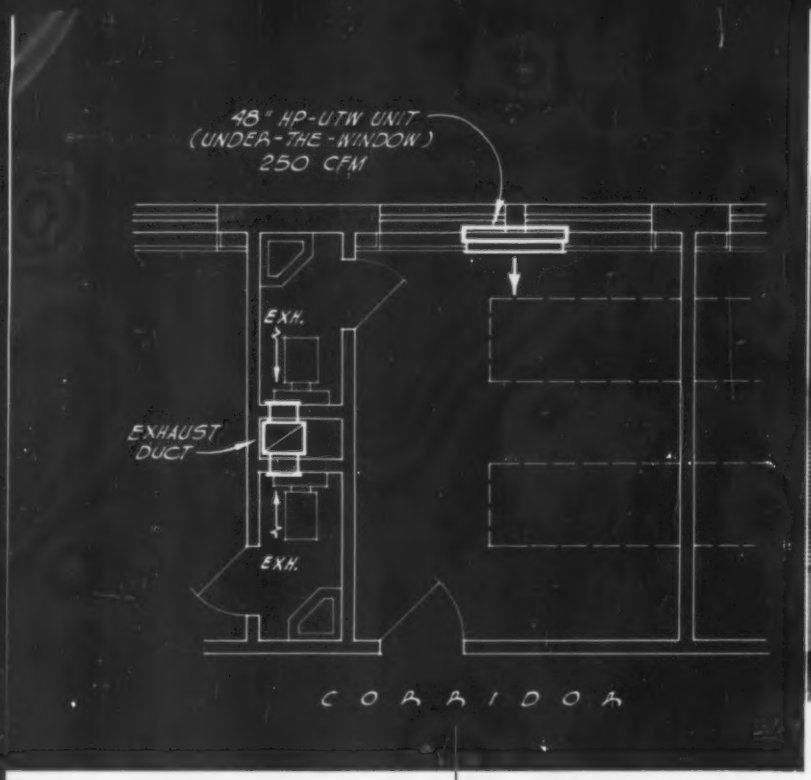

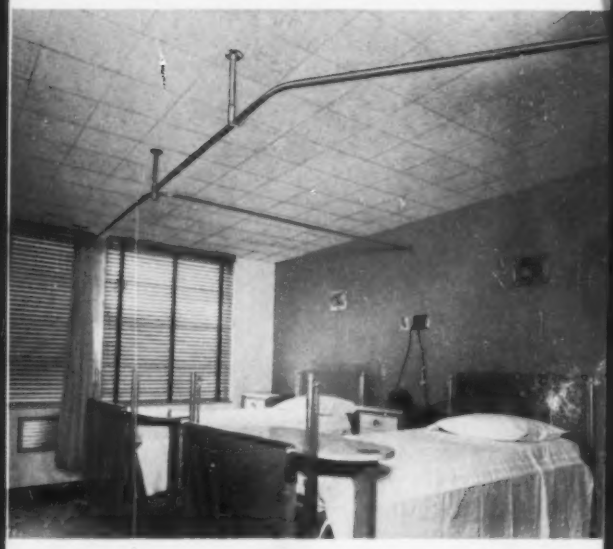

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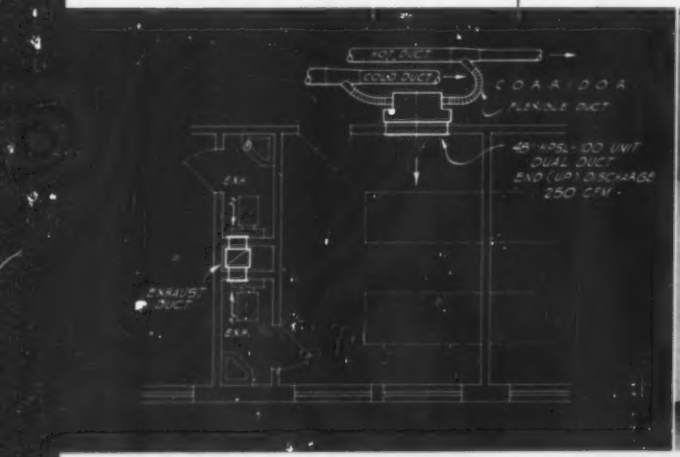

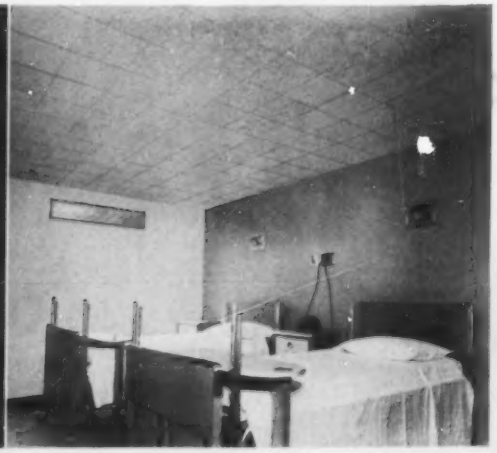

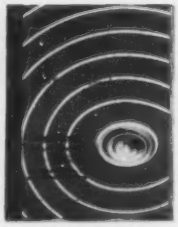

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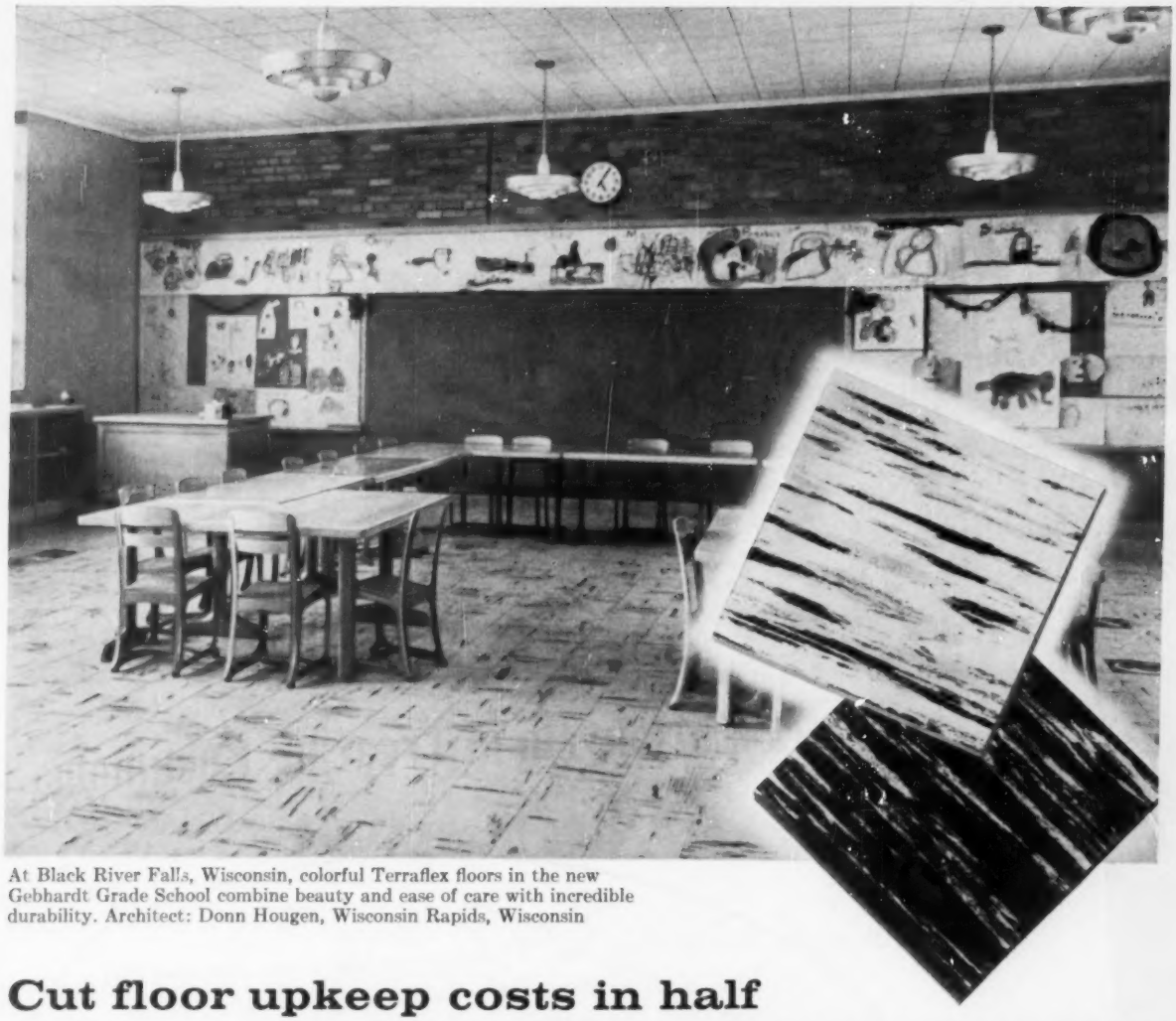

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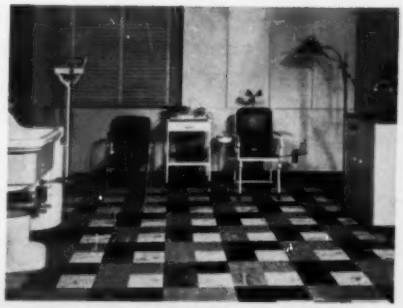

In hospitals and school dispensaries, Terraflex resists mild acids and disinfectants. Its nonporous surface can be kept sanitary with a minimum of care.

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Erythromycin in Treating Pneumonia

A 27-year-old man, a chronic alcoholic, was admitted with a history of an alcoholic spree followed by a cough, greenish sputum and chills and fever.

Physical examination showed a temperature of 104 F. and indicated pneumonia in the right lower lobe. This was confirmed by X-ray. The sputum revealed gram-positive diplococci and blood culture subsequently grew Type VII pneumococci.

The patient was treated with erythromycin, 300 mg. every six hours per os. His temperature dropped to normal by 48 hours and X-ray of the chest revealed considerable clearing by the fourth hospital day. After 10 days hospitalization, the patient was fit for discharge.[1]

First Antibiotics Symposium, we reported the successful treatment with hromycin of *H. influenzae* pneumonia and bacteremia. A second patient with *H. influenzae* pneumonia and bacteremia had a clinical course almost identical to the one previously reported, with cure obtained by treatment with 500 mg. of erythromycin per os every four hours for 14 days.

Of these 132 patients with bacterial pneumonia, 127 (96%) had a good clinical result. One patient with lobar pneumonia had a good initial response but had delayed resolution after treatment.

"Highly Effective in Pneumonia"

In one investigation, 75 adult patients with bacterial pneumonia were treated with erythromycin. In his summary, the clinician reported: "It is concluded that erythromycin is highly effective in the treatment of pneumonia due to gram-positive bacteria."[2]

This, of course, is only one of many reports showing the effectiveness of ERYTHROCIN against coccic infections. You'll get the same good results (nearly 100% in common, bacterial respiratory infections) when you prescribe ERYTHROCIN. Abbott

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After a study of 171 patients treated with erythromycin, the investigator wrote: "No serious side effects occurred with prolonged therapy or with doses up to 8 Gm. per day in the severe infections."[1]

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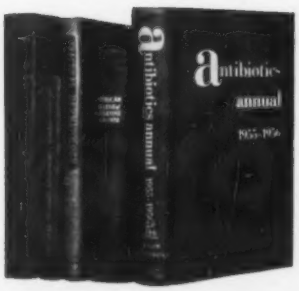

1. Romansky, M.J., et al., Antibiotics Annual 1955-1956, p. 48.
2. Waddington, W. S., Maple, F. C., and Kirby, W. M. M., A.M.A. Archives of Internal Medicine, 1954, p. 556.

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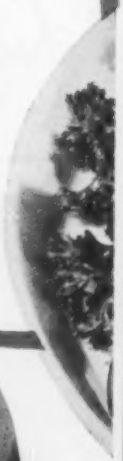

Too often it is humorously remarked, "the things which are good are not good for you." With turkey, just the opposite is true. For turkey meat is both highest in protein and very low in calories—as recent tests made by Cornell University clearly prove. So turkey is both good and good for you.

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"Research in nutrition over the past decade has shown that the average American needs to reduce his caloric intake so as to prevent overweight, and in addition to this he needs to make certain that a large portion of his food consists of high-quality protein. Excessive fatness shortens life and limits its usefulness and enjoyment. This research with men and animals indicates that by consuming a higher protein diet and cutting back on our calories we will be eating all of the protein and vitamin nutrients needed for growth and repair of wear and tear in our tissues without consuming excessive amounts of calories which can only be converted to fat.

"In recent studies at Cornell University we have shown that all of the animal meats are high in protein but that turkey stands out above all the rest. The turkey is highest in protein and low in calories. Turkey is also higher in the important B vitamins, such as niacin and riboflavin. These results show, therefore, that from a nutritional point of view we cannot go wrong in making turkey meat an important part of our diet."

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1. Eckenhoff, J. E.; and Dripps, R. D.: **Anesthesiology**, 15:681, Nov., 1954.

2. Sokoloff, Louis; King, B. D.; and Wechsler, R. L.: **Med. Clin. North America**, 38:499, Mar., 1954.

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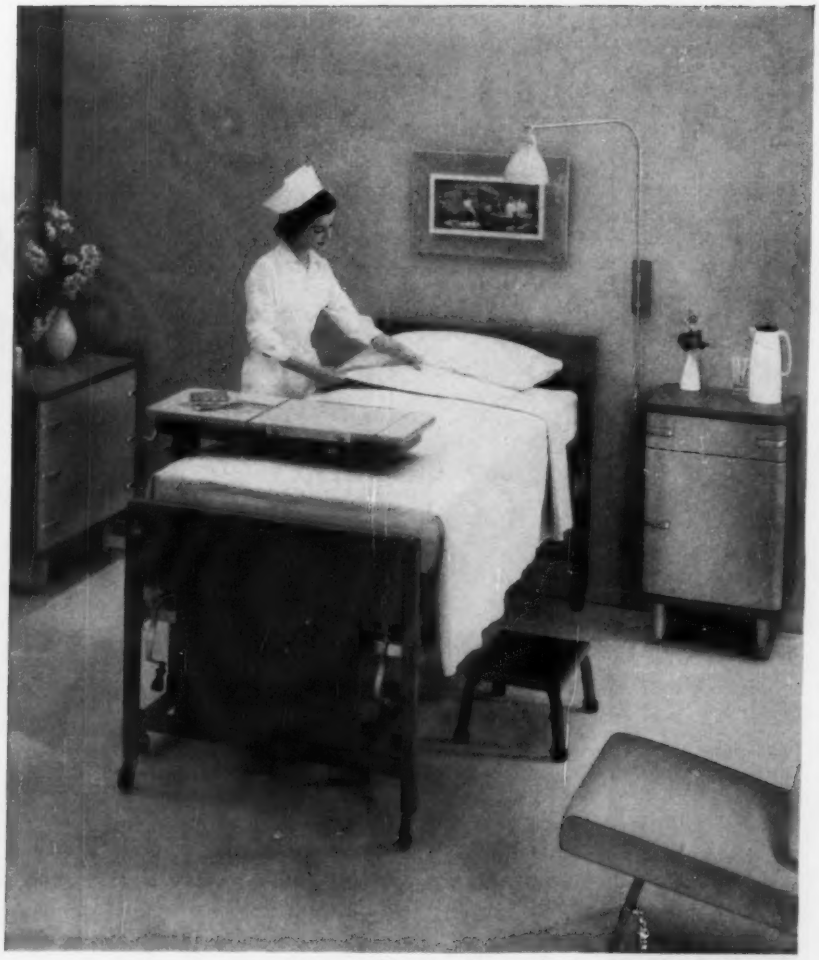

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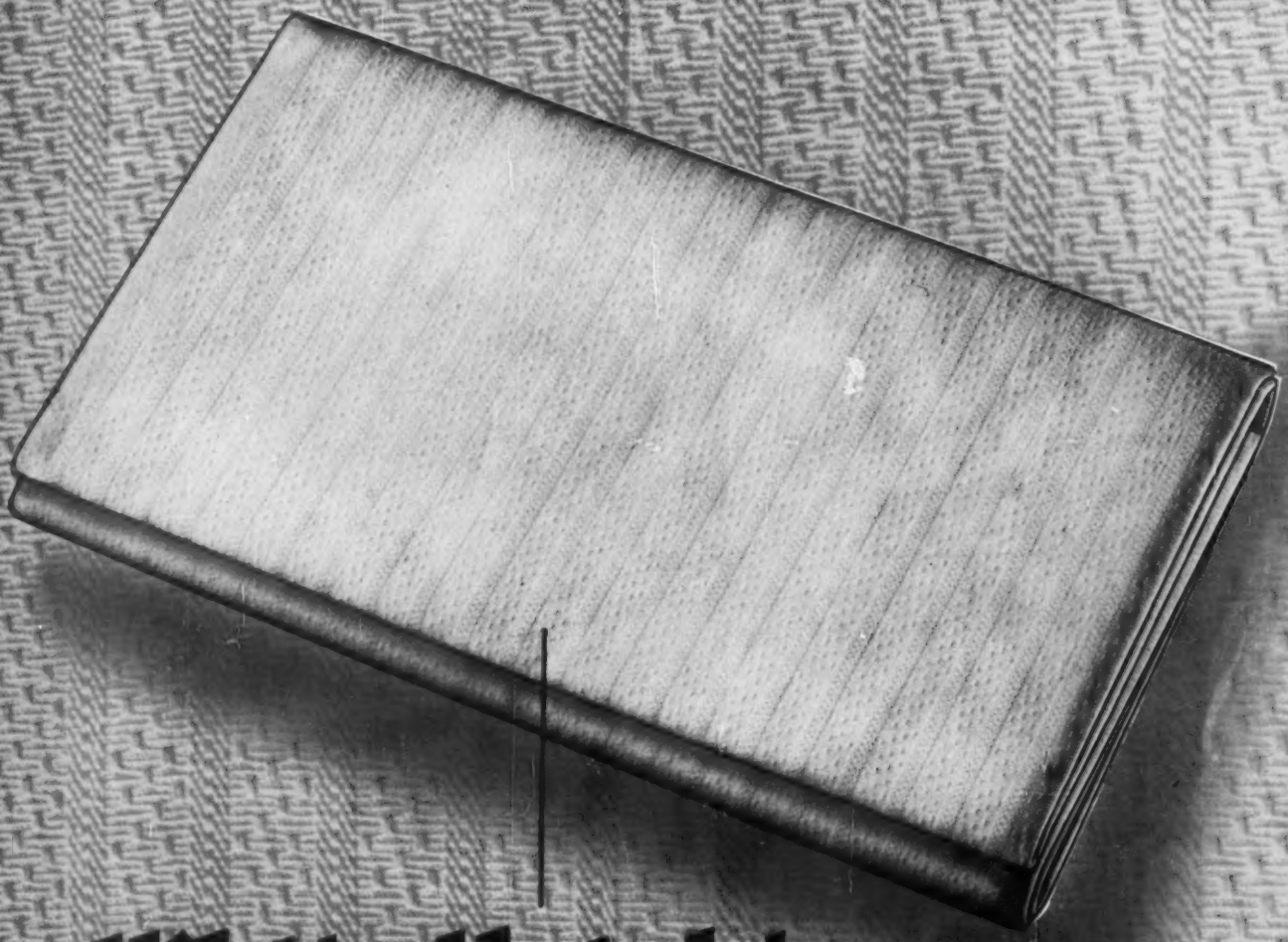

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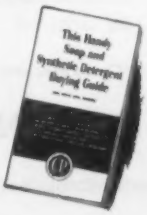

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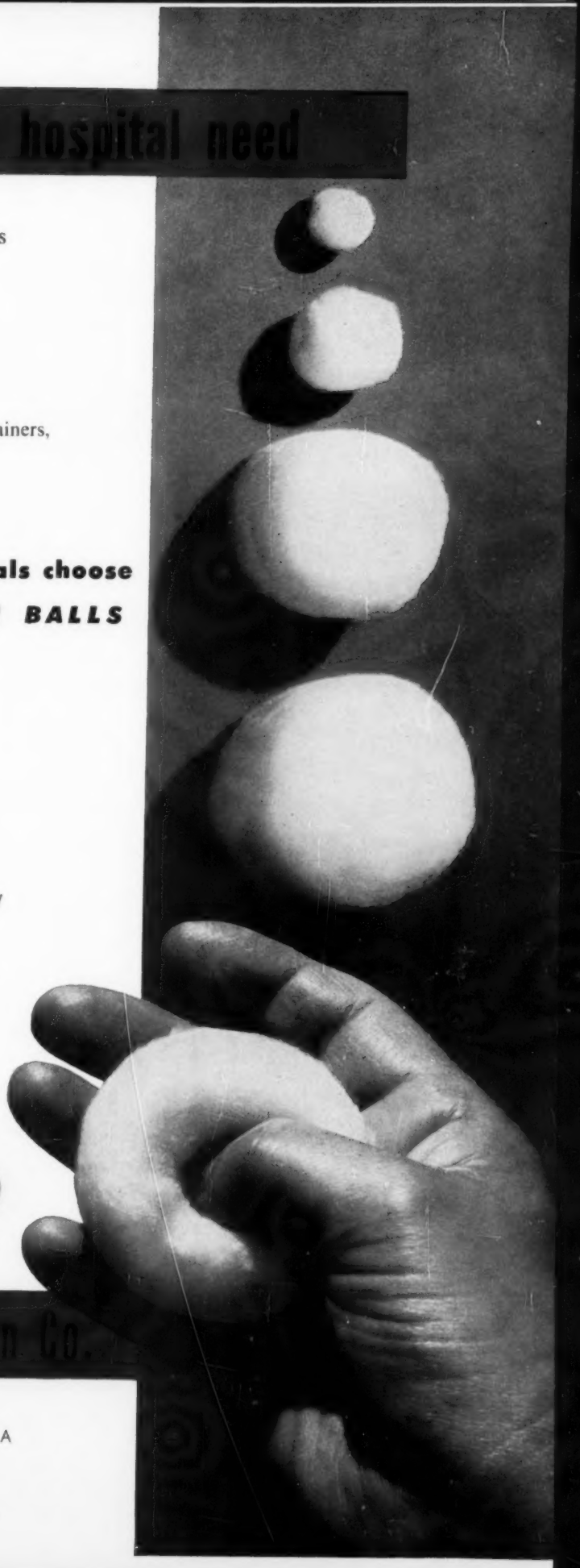

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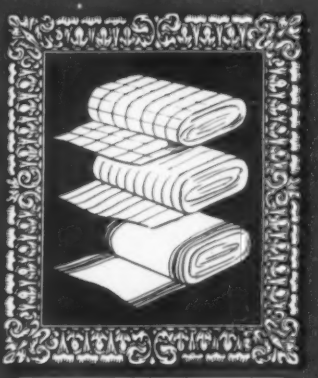

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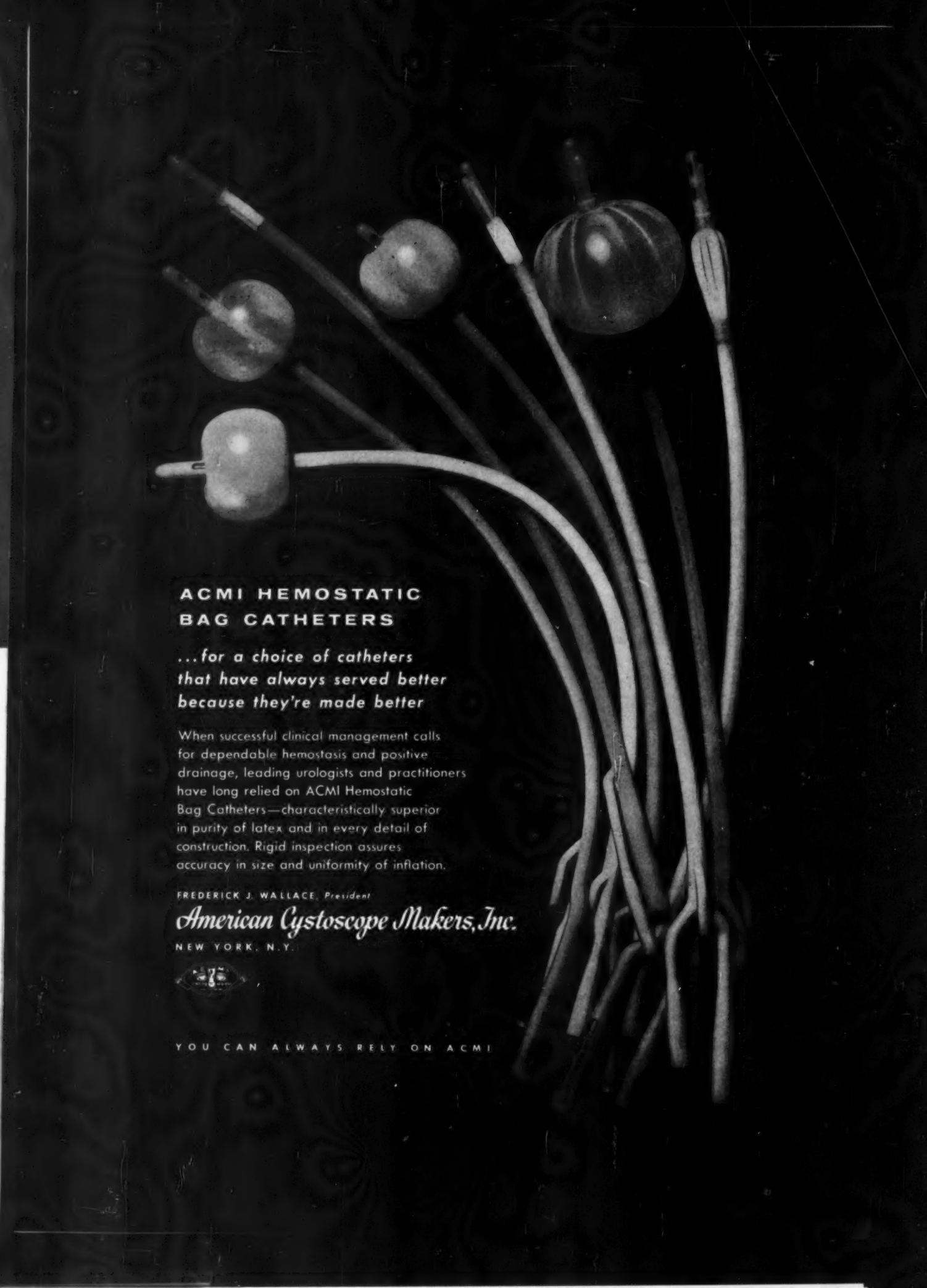
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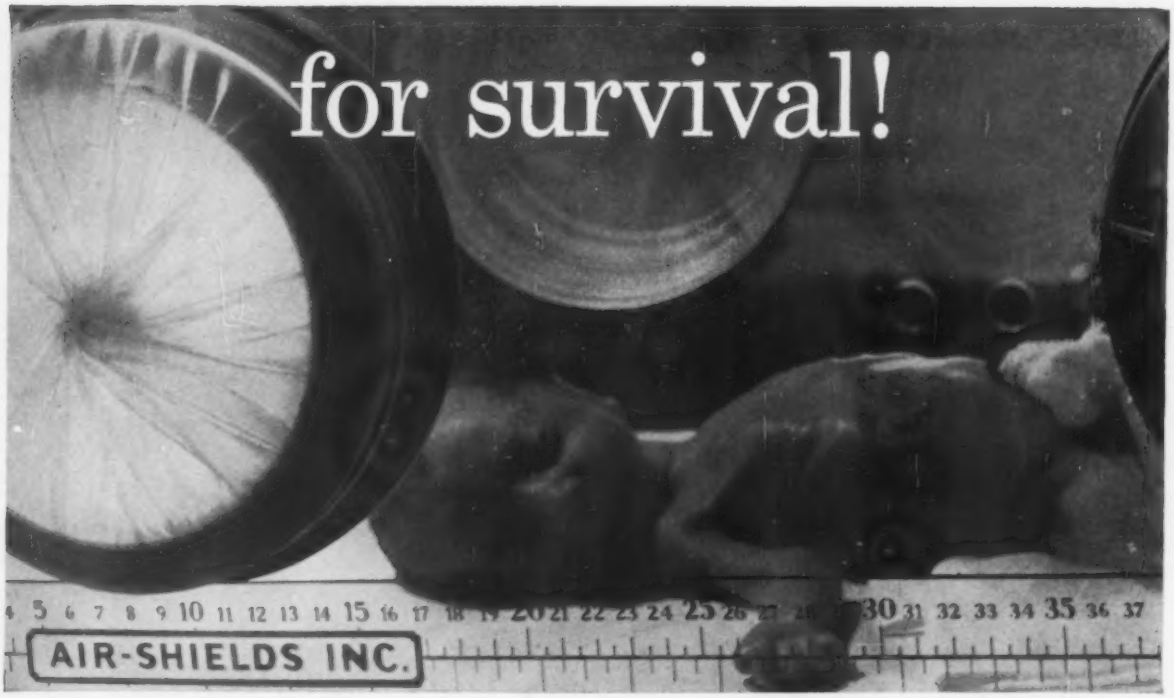

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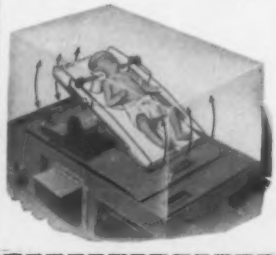

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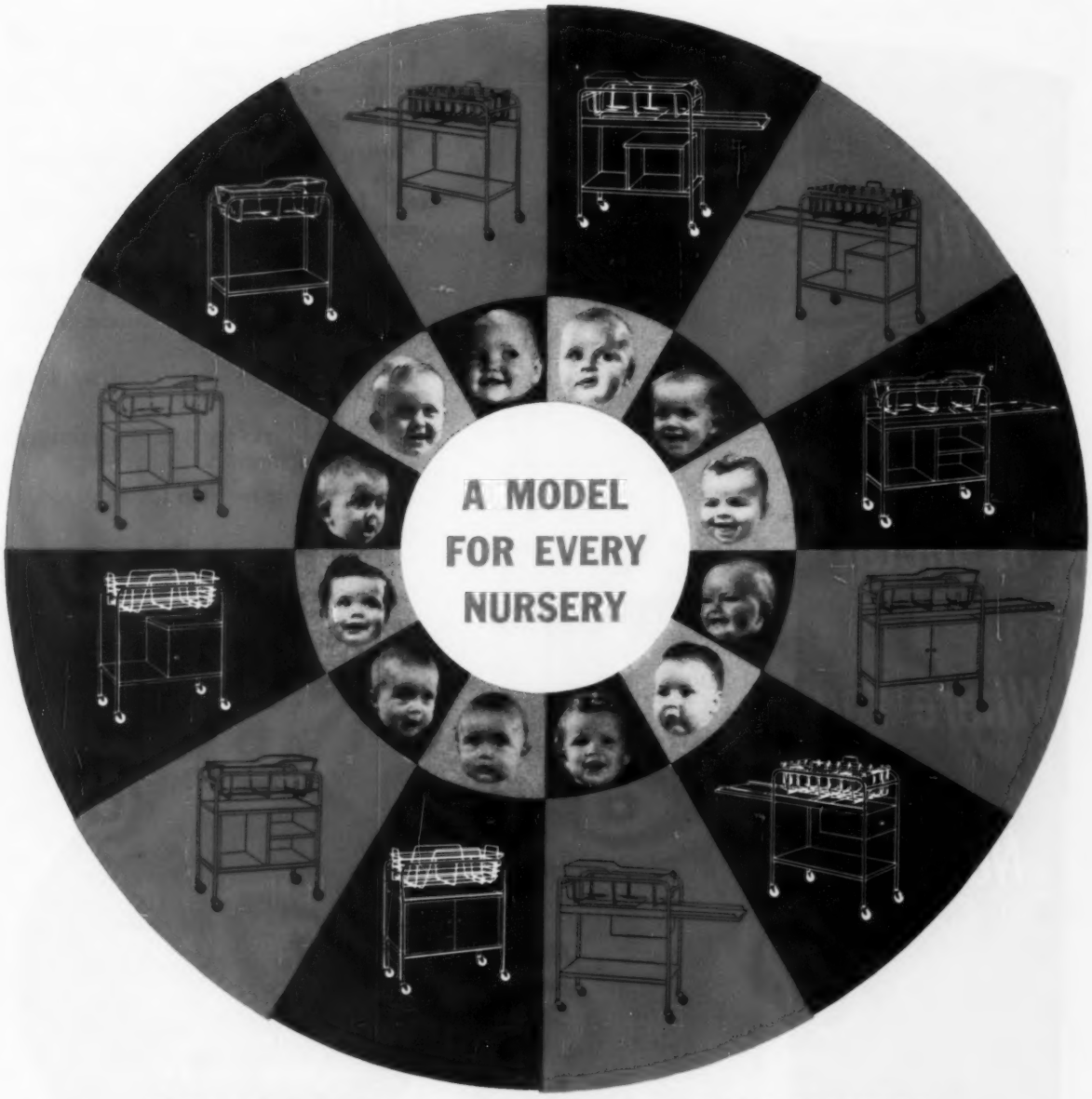

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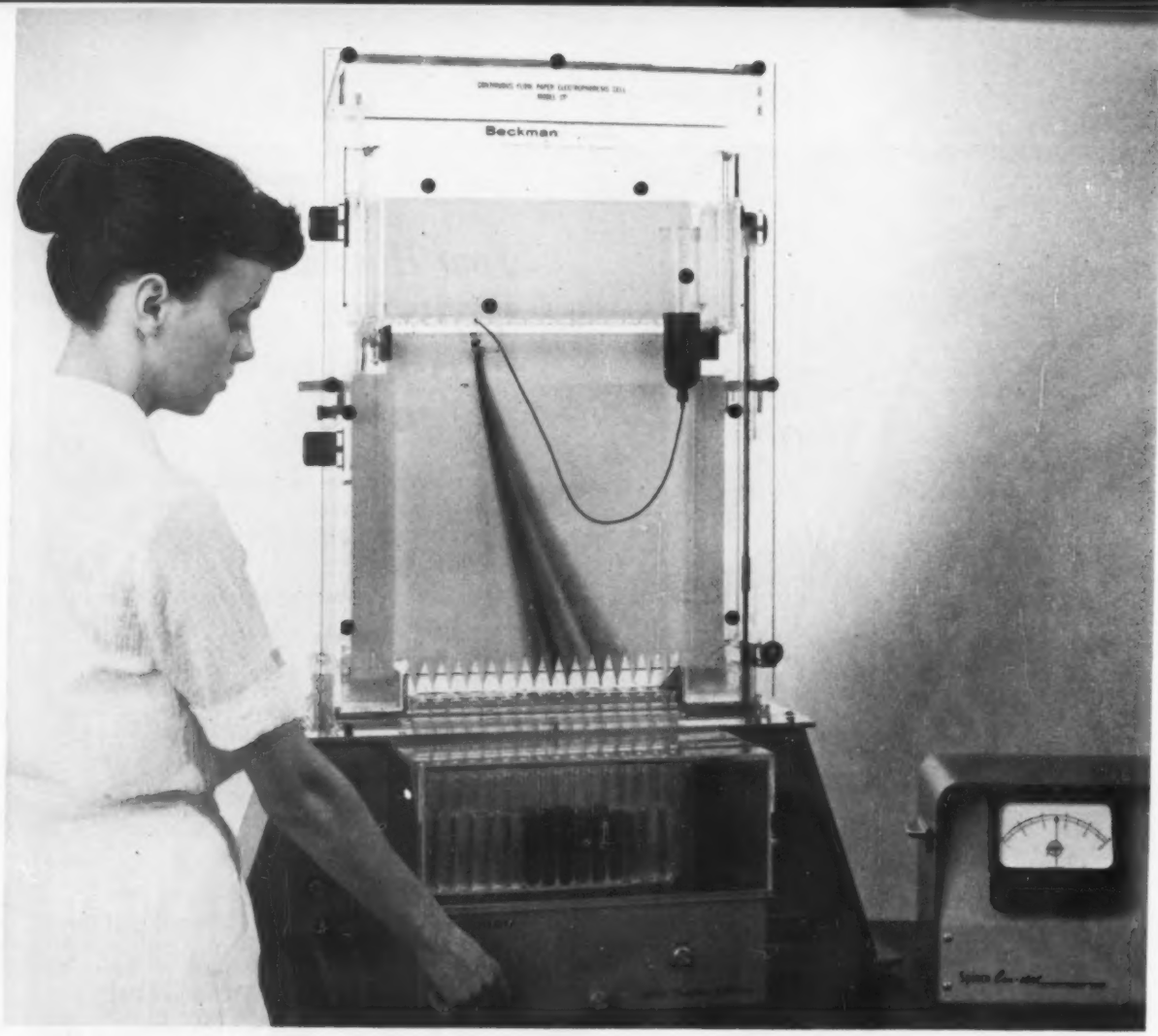

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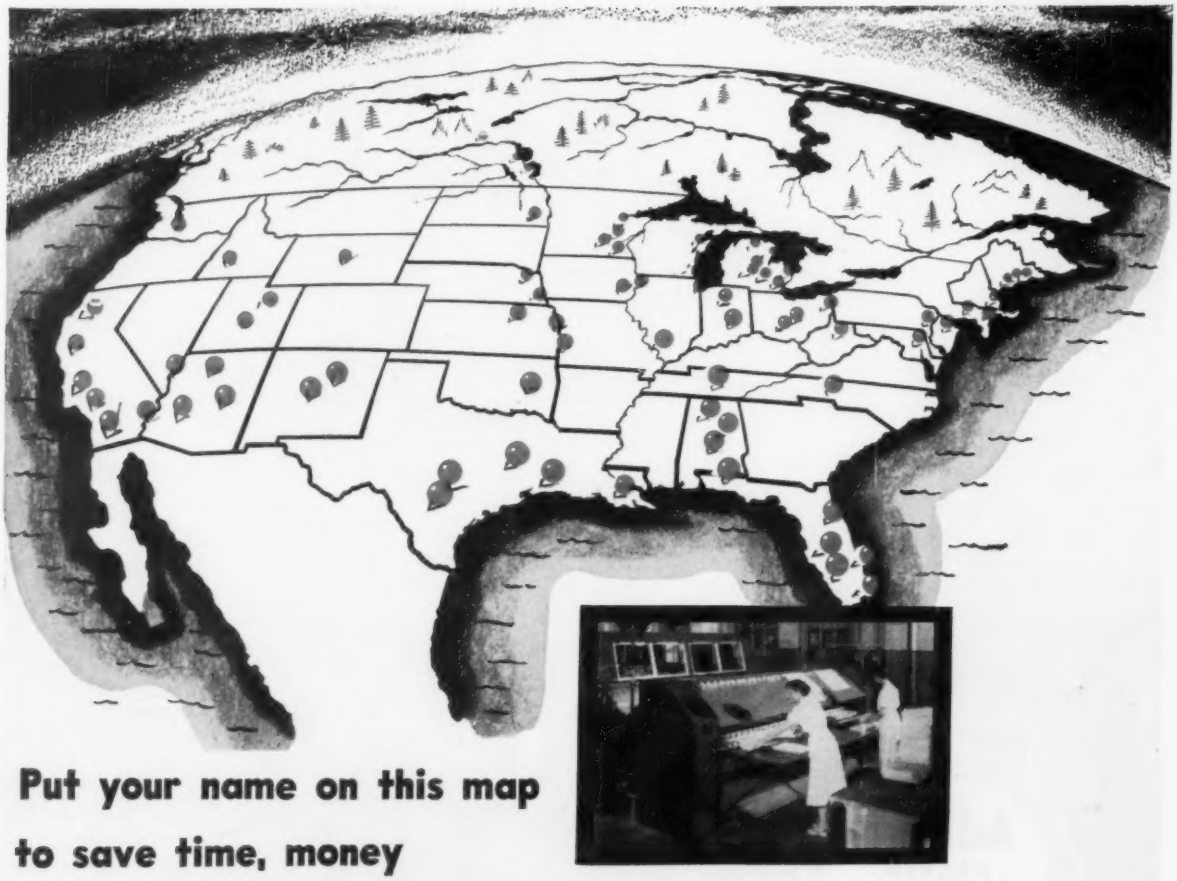

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SMALL HOSPITAL QUESTIONS

Calculate Depreciation

Question: We do not include depreciation on plant and equipment as an operating cost and have been told by the auditing firm that makes our annual audit that this practice is not common in the hospital field. Nevertheless, some of our trustees feel we should make a depreciation charge and include this as operating expense in calculating costs. What is the common practice among smaller hospitals?—R.O.J., Conn.

ANSWER: The majority of hospitals now calculate depreciation on plant and equipment and figure this as an operating expense, though it is rarely actually "funded" in most cases. However, in many communities the feeling still prevails that the hospital plant is provided from philanthropic sources, and will eventually be replaced out of community resources, and therefore it is improper to include plant depreciation as an operating expense. There is an extensive literature on both sides of this question.

Concessions Are in Order

Question: We are plagued as always by the shortage of graduate nurses for hospital duty and recently have broken a long established policy that all graduate nurses on general staff duty must take their turns at working nights, week ends and split shifts. This has caused trouble, and some of our older, devoted staff members have threatened to quit unless we compel newly employed nurses to share the less desirable assignments. What would you advise?—W.O.N., Iowa.

ANSWER: Theoretically, it is bad personnel practice to make special rules for special groups of employes—that is, to give some staff members the privilege of declining the less desirable assignments, while others are required to accept these assignments. Nevertheless, in many communities today it is necessary to make these concessions in order to utilize the nursing services available in the community. It is likely that those who decline night and week-end duty are married and have children or other family responsibilities that make it impossible for them to work at all unless some such arrangement may be possible. This circumstance should be explained fully to all concerned. As long as any concessions that are made have been made with a view to maintaining nursing service at adequate levels, and not simply in response to pressure from any group or individual who does not want to work as hard as others, the administration's position is essentially right. This does not mean, of course, that under today's conditions there will not always be problems of this kind to which there is no easy answer.

Change Without Friction

Question: Recently, a member of our obstetrical staff who brings practically all his patients to our hospital came to my office and asked if I had any objection to changing one of the forms used on the chart in connection with obstetrical patients. I agreed to this request, suggesting that the change be cleared with the head of the division first. This he agreed to do and, later, the new forms were prepared and referred to the nursing office to be put in use on the floor.

A few days later, another member of the staff, most of whose patients are in surgery, discovered the new form and took it upon himself to order the floor supervisor to reinstate the old one, on the ground that only the staff had the authority to institute changes in forms provided for their use. I insist this is a management matter—part of the "rules, regulations and policies" that doctors agree to abide by when they join the staff and use our facilities. Is this correct?—J.C.R., Pa.

ANSWER: Yes, but that doesn't make the administrative procedure followed in this instance correct. If the change was approved by the obstetrical department of the staff and the medical records committee and put into effect through the regularly established procedure for making changes of this kind, then, certainly, no other staff member would have the right to order a floor supervisor to reinstate the former procedure. While all the details of the procedure by which the new form was adopted in this case are not stated here, there is a suspicion, at least, that the administrator and member of the obstetrical staff acted hastily and without proper clearance in adopting the new form. The ordinary procedure for accomplishing a change like this would be to have the particular staff member refer the desired change to the administrative office and the chief of his department at the same time. The entire staff in the obstetrical department should have had a chance to study the contemplated change and express opinions on it; the department should then have made a recommendation to the medical records committee of the staff, and, following study, the medical records committee should then have made a final recommendation to the administrator for action.—E.W.J.

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; A. A. Aita, San Antonio Community Hospital, Upland, Calif., Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Standards for Painters

Question: We are trying to work out standards for our maintenance crews in line with modern practice in industry, and would like to know how many square feet per hour a painter should be able to cover, using a high grade, flat wall paint.—F.C.G., Mo.

ANSWER: Authorities in industry say the average painter should be able to cover 275 square feet an hour. This is qualified, however, by such factors as the type of surface, condition of surface, number of corners, windows and other irregularities affecting the speed with which painting surfaces may be covered.

Who Buys Uniforms?

Question: Do most hospitals furnish nurse's aides, orderlies and other personnel with uniforms and uniform laundry service, or do these employes buy their own uniforms and pay for laundering?—S.A.J., Ore.

ANSWER: In line with prevailing practice in industries employing uniformed attendants, it is increasingly the practice in hospitals today to furnish uniforms for employes without charge, and to launder employes' uniforms. Personnel executives believe this practice permits better control of the appearance of uniformed employes, in addition to creating better employe relations. However, the practice is not universal among hospitals.

wire from Washington

MEDICARE

Although there was some grumbling from a score of state societies and individual hospitals, the Defense Department's program for medical care of military dependents went into operation on December 7, as scheduled.

Early in the fall the army, executive agent for all uniformed services, decided to divide up the hospital phase of the program, giving Blue Cross the east and west coasts and commercial insurance interests the central section.

When time came for contract signing, the agreements were signed. Blue Cross signed for its allotted states. Mutual of Omaha signed for the others, with the understanding that it would spread the risk among at least two other commercial companies.

In the division of territory, the army admitted that its decision was somewhat arbitrary, but it insisted on preserving competition in this field. Thus, if the insurance states might show too high a cost in comparison with the states under Blue Cross coverage, Defense Department naturally might consider shifting more states to Blue Cross. But the expectation is that administrative costs will run about the same. There is no "insurance" factor in either case, as Blue Cross and the commercial companies will merely accept the bills and pass on the money to the hospitals.

With the program now well under way, some state hospital societies still hope for a shift from commercial to Blue Cross, as do a number of individual hospitals. Defense Department, however, is standing firm. It is willing to renegotiate contracts before next June 30 if experience shows a change would be advisable, but it is not anticipating shift of contracts in either direction.

NELSON COMMITTEE

Mostly because it has no money, a special government committee to study hospital administrative problems continues to make slow progress. The committee was appointed last September by Secretary Folsom. Its assignment essentially is to try to find ways to reduce hospital costs for patients who don't require complete service.

Now the group, under chairmanship of Dr. Russell Nelson, director of Johns Hopkins Hospital, is making a comprehensive study of pilot projects recently completed or currently under way at hospitals. These are studies generally undertaken by individual hospitals without any financial help from the federal government.

Also, the committee is asking other hospitals to undertake investigations (at their own expense) or to set up pilot studies covering the needs of patients convalescing from acute and chronic illness and those who require only diagnostic services and facilities. If methods can be developed to provide them with the care they need without making use of all the expensive hospital facilities, the costs to the patients can be reduced substantially.

While there is no question of the ability of the committee, and its determination to get the job done, it is working in a financial vacuum. It had anticipated that some of the Hill-Burton program's research money would be available. However, before the committee was able to get into operation all the H.-B. research money had been pledged or allocated. It is expected that the committee will have access to this fund when the next fiscal year starts July 1.

Meanwhile, committee members are hopeful that private foundations will come to their assistance so some specific projects can be financed in the next few months.

HEALTH INSURANCE

As the 85th Congress convenes, there is abundant evidence from all sources that before it finishes its two years it will have enacted some sort of legislation to give a shot in the arm to voluntary hospital-medical insurance.

President Eisenhower stubbornly refused to give up hope for a reinsurance pool to stimulate coverage, although the idea was defeated in one session of the last Congress and ignored in the other. Now he is demanding that Secretary Folsom get some action from Congress. He is not calling for a reinsurance pool necessarily, but for some tangible federal activity in this field.

Mr. Folsom has spent two years (before and since he became secretary) on the same project, but mostly in behind-the-scenes planning and negotiating. So he is accepting the White House assignment with enthusiasm. Mr. Folsom's patient quiet efforts have at least shown him that two of his ideas won't work. The big commercial insurance companies have turned him down on his offer to get monopoly laws waived so they could set up their own reinsurance pool, and the nonprofit organizations also walked out on him. This dream ended in an innocuous little bill to authorize pooling, a bill that went up to Congress late last session and was promptly forgotten by everyone.

The President and Mr. Folsom are determined to get something done that will facilitate hospital-health insurance for four groups of the population:

1. **The aged,** generally those past 60, who are dropped out of many policies and find they are ineligible for others because of the age factor alone.

2. **Low-income groups,** which find it difficult to afford premiums for the type of hospital-medical coverage they need.

3. **Farmers,** most of whom can't obtain good and reasonable coverage because they are not part of a group.

4. **Individuals** who can't obtain coverage either because of their employment status or because of medical conditions.

The White House is open-minded on how these people should be helped, but any program that does not offer assistance to all four groups probably would not be accept-

able. Direct subsidies would be distasteful to the White House, but they may be the ultimate answer.

The Democrats, controlling Congress, agree with the White House that something should be done to bring about a rapid spread of health insurance. But not unexpectedly they want to move a little farther and a little faster than do the Republicans. The most important difference is that they would have no philosophical qualms about subsidies.

Holding the Democrats' interest right now is an idea that originally was advanced by two Republican senators, Ralph Flanders of Vermont and Irving Ives of New York. Under this plan the federal government would underwrite the formation of a nationwide network of health insurance plans, operating under state control.

To ensure that everyone could obtain coverage, regardless of income, occupation, residence or medical history, the federal government would make financial grants to the states annually. The states, in turn, would have to ensure that premiums would be scaled to income. There would be no charge, of course, to the indigent, and low-income or "medically indigent" families would pay only part of the premium. The federal money would be channeled to make up the losses suffered in providing hospital and medical care for these two groups. Those with moderate or high incomes would pay the full cost of coverage.

If the Eisenhower Administration can't come up with some substitute, the Democrats will be certain to push the Flanders-Ives idea, with prospects good that it will be enacted.

FEDERAL EMPLOYES

In advance of hearings before the House civil service committee on health insurance for U.S. workers, the powerful American Federation of Government Employees came up with its own plan. Under it the U.S. would not set up any type of insurance organization, as has been proposed in the past. Instead the U.S. would establish certain criteria for plans now in existence, including length of hospital stay, services covered, termination of coverage, and so on. The employe then could select any profit or nonprofit plan or plans that met the requirements, and purchase basic insurance, major medical insurance, or both. The federal government's rôle simply would be to pay half the cost.

To make this work, obviously there would have to be payroll deductions. Whether the administration will change its position and approve the deductions still has not been decided. One important factor will be the findings of the General Accounting Office, which has about completed a survey on the cost and complications of payroll deductions in federal agencies. G.A.O. first queried commercial and nonprofit health insurance plans on what they would require from the agencies in the way of technical information and services. Then, on the basis of the replies from the carriers, G.A.O. questioned the agencies on the cost, inconvenience and other problems involved in complying with the carriers' demands.

The Civil Service Commission meanwhile has a double responsibility. It has to be ready with a program that can be put into effect if payroll deductions are authorized, and at the same time it has to be prepared for a different approach if the White House says no deductions, and Congress declines to override the Administration on this point.

At any rate, the Commission will argue that major medical insurance be a firm part of any program enacted by Congress.

P.H.S. RESEARCH GRANTS

Four grants, totaling $163,060, have been announced by the Public Health Service for research in hospital administration and service. Topping the list was a grant of $100,000 to American Hospital Association for research in the better planning of hospital design, in cooperation with the American Institute of Architects.

Other grants: St. Vincent's Hospital, New York City, to develop scientific personnel systems and methods; Joint Blood Council, Inc., for development of standard terminology for describing the work in this field; University of Oregon Medical School, $4460 for a study of the needs for training medical technologists.

MEDICAL SCHOOL AID

Another prospective piece of legislation—for U.S. aid to medical schools—also has bipartisan support. The Democrats might be inclined to go all the way, against the almost certain opposition of organized medicine, and plug for money to help pay operating costs of the schools as well as their construction and equipment expenses. Frightened of the possibility of federal control or influence if U.S. money goes for operating costs, the Republicans can be expected to work for construction and equipment grants, but to oppose the use of U.S. money for such regular expenses as staff salary and maintenance.

Whatever their differences as to the approach, both parties agree that medical schools need some federal help.

HELP FOR AGED

One issue of great interest to hospitals—free hospitalization of the aged—will find a wide gulf between the parties —so wide that it can't be bridged by any compromise. For this reason, if no other, the plan won't get far. But it has the makings of a loud and perhaps bitter fight this session of Congress.

This idea was first offered more than six years ago by the then federal security administrator, Oscar Ewing, with the blessing of President Truman. It would offer to every person covered by social security 60 or 90 days of free hospitalization a year, provided he or she was 65 years of age or older. The patient would not have to be retired. The money would come out of the social security trust fund, and there would be no additional tax.

NOTES ON NURSES

Between 650 and 700 graduate nurses will receive U. S. help this year to further their professional education. Grants totaling nearly $2 million have been announced to 56 schools of nursing and public health. Out of the grants schools award traineeships for courses in nursing administration, supervision and teaching. One of the objectives is to help nurses who have been attending school part time to complete their work.

More than 50 army nurses participated in the first national postgraduate workshop in anesthesiology in mid-November at Walter Reed. Included were reserve nurses as well as those in the regular army. A feature of the week's course was three closed-circuit telecasts from operating rooms in the hospital. Maj. Margaret E. Connor of the Walter Reed staff was director.

The Modern Hospital
JANUARY 1957

LOOKING AROUND

History Lesson

PUBLISHED histories of individual hospitals are fairly common in England and on the continent, where a hospital is likely to be several hundred years old and to number among its patrons a liberal sampling of colorful kings, marquesses and lords, and where the wards have probably been occupied by heroes of the conquering and conquered armies of half a dozen wars. In the United States, however, hospital histories are a rarity; most of our hospitals are too young for history, and, besides, Americans like to think about tomorrow rather than yesterday. Only a handful of American hospitals have published histories, and most of those we have seen have been colossal bores, consisting largely of long excerpts from the minutes of board meetings, speeches at groundbreaking and dedication ceremonies, and statistical acrobatics demonstrating the number of times the annual consumption of adhesive tape would reach from Philadelphia to Phoenix and back again.

Happily, the latest hospital history to be published here* breaks this dreary mold. With a 75th anniversary to celebrate and a proud history to relate, directors of Chicago's Michael Reese Hospital a year ago made a sensible decision. Instead of turning the job over to a talented member of the women's board or hiring a good-natured but uninspired hack, as other hospitals have done, they found a trained medical reporter who is also a skillful, sensitive writer and persuaded her to take on the assignment. The result is a hospital history that reads, as many delighted readers have observed, like an exciting novel. From the dramatic narrative of a famous Reese patient—Dorothy Mae Stevens, the "frozen woman" who survived—with which the book opens, to the final chapter on volunteer spirit and services, the story moves swiftly and easily across the years. Events take shape and people spring to life in a succession of well told episodes, with a minimum of recourse to the archives and grudging use of the deadly statistic.

Inevitably, the Michael Reese story rises to its climaxes in its accounts of medical accomplishment, but if there is a writer anywhere who can make lively reading out of a hospital bookkeeping system or housekeeping routine, it is Lucy Freeman. Especially, hospital people will be fascinated by her story of far-sighted planning for development of the medical center. When the Michael Reese board announced its plans for expansion ten years ago, skeptics in the hospital field —including, it must be confessed, this magazine—thought that board members had been smoking opium. "They should stick to running the hospital," was a comment that was heard on all sides, "and not try to rebuild the city." As it turns out, Michael Reese has done both; new hospital buildings have risen from the slums of a few years ago, and Miss Freeman's report of how this was done should be an inspiration to hospital administrators and trustees whose vision outruns their courage.

If the book has a flaw, and it has, it is not so much the fault of the author, or the hospital, as it is of our culture and its Fallacy of Infallibility—the concept of public relations that makes admission of shortcoming or failure the unforgivable sin of any profession, institution, business or government. Obedient to the Fallacy, this history makes Michael Reese surgeons appear the greatest of all surgeons, its administrator the very model of a modern administrator, its board the most astute and generous of boards, its research the wellspring of medical knowledge, and its psychiatrists without peer among head-shrinkers—until the reader, engrossed as he may be in the unfolding story, begins to wonder how patients who are so unlucky as to land in other hospitals can possibly survive.

Occasionally, Miss Freeman has contrived to slip in the critical needle, as when she reports that a staff member who was hospitalized at Reese wrote, "Some of the maids who carry trays to patients don't say good morning, good night, or go to hell." But the critical observations are heavily inter-

*Hospital in Action, The Story of the Michael Reese Medical Center, by Lucy Freeman. Chicago: Rand McNally and Company, 1956. Price, $5. Pp. 302.

larded with massive doses of hallelujah and restricted for the most part to lesser considerations such as maid service, laundry and roof maintenance, which can scarcely be expected to command the whole attention of the gods.

Actually, if the gods only knew, at Michael Reese and elsewhere the Fallacy of Infallibility hurts doctors and hospitals more than it helps them. The public is not a fool; detecting something phony about the mantle of nobility in which doctors and their public relations geniuses like to wrap the profession, it suspects that things are worse than they are and believes less, instead of more, than the truth. The occasional outbursts of public criticism of doctors and hospitals that cause so much anguish in the profession may be less damaging to public esteem, on the whole, than the assumption of ineluctable virtue which is so prevalent, so suffocating and so unbelievable. As a man makes more friends by saying, "I am wrong," just once than by repeated protestations of righteousness, it seems likely that the critical outbursts about medicine might be less frequent, and less severe, if the profession itself would drop its guard once in a while and acknowledge a fault on its own time.

Of course, nobody in his right mind would expect Michael Reese Hospital to publish a history devoted largely to kicking Michael Reese doctors around, but the hospital might have gained rather than lost if Miss Freeman had been permitted to tell a few of the anecdotes that hurt, as well as those that glorify. In America, we are committed to the proposition that the common people have common sense, but only a few of us, apparently, really believe it.

Tale of Two Houses

SITTING as an observer at the recent meetings of the House of Delegates of the American Medical Association, we were impressed, as we have been on many occasions in the past, by the extent to which delegates and members of the A.M.A. take part in the discussion and debate leading to action by the House of Delegates creating A.M.A. policy—in contrast to the House of Delegates of the American Hospital Association, where few issues are debated, few members take part in the discussions, and, usually, only a handful show up to look on.

Several factors, it has seemed to us, may account for the difference. First, the doctor is an individualist, accustomed to acting by and for himself, fiercely interested in association rules and policies that directly affect his practice and his conduct, whereas administrators in the House of Delegates of the A.H.A., perhaps, are less individualistic and more "organizational" by nature, and it is their institutions, primarily, and only less directly themselves, that are affected by the actions and policies of the association.

Secondly, the political structure of medicine is less top-heavy than that of the hospital association. County and state medical societies are a powerful force in medicine, and, contrary to the popular notion, the A.M.A. derives its strength from its constituent associations, and not vice versa. In the hospital world, on the other hand, the A.H.A. is all-powerful; rank-and-file members, and even delegates, are somewhat awed in the presence of national officialdom. Happily, state and regional associations and local hospital councils are gaining strength rapidly today, and in a few years it may be expected that many state associations, like state medical societies, will send their delegates to national meetings instructed to stand up and be heard, at whatever cost of unpopularity.

Finally, there is a difference in method. In the A.M.A., reports and resolutions from all sources are introduced to the House of Delegates, then referred by subject to one or another of a dozen reference committees, where open hearings are conducted, frequently lasting all day, and where delegates and members—often several hundred at a time—appear freely to present whatever facts or opinions they may feel are relevant to the issue. On the basis of these hearings, the reference committees may then approve, disapprove or amend the reports and resolutions, bringing them for final action back to the floor of the House, where further discussion may, and frequently does, take place. Final action by the House of Delegates of the A.M.A., then, usually reflects the true desire of the delegates, which in turn reflects the true desire of constituent societies and their memberships—a circumstance, to be sure, which can sometimes result in policies that are vague or ambiguous.

In contrast, meetings of the House of Delegates of the American Hospital Association in recent years have been held following "briefing sessions" conducted in widely separated regions. Theoretically, at least, these briefing sessions, like A.M.A. reference committee hearings, provide an opportunity for full discussion of reports and issues and are informative in nature. But only delegates from the regions attend, and some delegates have felt the sessions operate largely to acquaint them with policies that have already been laid down by A.H.A. councils and trustees, with the result that little if any discussion is carried into the House of Delegates itself. Thus in many cases association policies are formalized, but not really formulated, by the House.

It may be argued that the flow of authority from the top down, as exemplified in the A.H.A., results in more positive and more consistent policies and action than are possible when authority flows from the bottom up. But it seems plain that the greater danger lies in nonparticipation. A strong association, like a strong government, gains power and momentum from the exercise of authority and the passage of time; unless a conscious effort is made to keep constitutional checks and balances operating and to encourage widespread participation, the executive department can easily become so powerful that opposition or dissent diminishes and then vanishes—until, finally, the government represents itself instead of the members.

Nobody wants this to happen in the American Hospital Association. The growing strength of state and regional associations, which will result eventually in decentralization of authority, is widely regarded as wholesome and desirable. Meanwhile, however, it would seem worth while for association leaders to consider, at least, something like the reference committee method to stimulate member interest and participation in association policy making.

Survey of Administrators' Salaries

In this group of 56 hospitals, most of them in smaller size groups, wide variations in salary levels were reported within each classification. About half of the group receive "fringe benefits"

ADMINISTRATORS' salaries disclosed in a recent survey conducted by a state hospital association ranged from $4200 in hospitals of 25 beds or less to $12,000 in hospitals of 170 beds and more—plus perquisites varying from simple expense accounts to a generous "car, residence and full maintenance" in one case.

Results of the survey, which included 56 hospitals, mostly in small towns and rural communities and in the smaller size groups, were released by the association, which requested, however, that the state should not be identified in any published report.

Average salaries reported by administrators in each hospital size grouping are shown in the accompanying tabulation, which also indicates years of service, vacation privileges, sick leave, and other details of the compensation of the reporting administrators.

Administrators taking part in the survey were asked to report their current salaries and the salaries at which they started on their present jobs, and then to estimate the maximum salaries they could receive in these jobs. The averages of each of these figures as reported are shown in the tabulation.

Within each size classification group, wide variations appeared in the salaries reported. In the smallest size group, for example, starting salaries ranged from $150 a month to $500 a month; current salaries in the 44-67 bed group varied from $400 to $830, and in the 85-118 bed group the lowest current salary reported was $665 and the highest $1165.

With only one or two exceptions, the starting, current and estimated maximum salaries increased consistently with the size of the reporting hospital. A notable exception appeared in the 119-167 bed group, where the highest current salary reported was $830 a month, whereas one administrator in the 85 bed class reported a salary of $1165 a month, and the average salary in this group was $830.

In addition to the information shown in the table, administrators were asked to indicate their educational backgrounds. Thirty-four administrators, or 64 per cent of the group, were college graduates; another seven administrators had some college training, and the remaining 12 administrators were high school graduates, it was reported. Generally speak-

AVERAGE SALARIES REPORTED BY ADMINISTRATORS

	25 BEDS	26-43 BEDS	44-67 BEDS	68-84 BEDS	85-118 BEDS	119-167 BEDS	OVER 168 BEDS
Starting Salary (mo.).....	$325	$375	$400	$350	$560	$500	$815
Current Salary (mo.).....	$355	$440	$515	$600	$830	$775	$1015
Maximum Salary (mo.)..	$535	$525	$555	$700	—	$1100	$1250
Years in Present Job.....	2	3	4½	3	5	7	3
Total Years in Field.....	3	5	7½	7	7	8	5
Vacation Period (weeks).	2	2	2	2	2	2	2
Sick Leave (days).....	10	12	12	12	14	12	15
Social Security.....	90%	80%	90%	66%	100%	50%	75%
Retirement Plan.....	10%	7%	25%	33%	0%	0%	25%

ing, the administrators with only high school training were in the smaller hospitals.

About half the group reported some perquisites or "fringe benefits" received in addition to cash salaries. Understandably, the most perquisites, and the most generous perquisites, were paid to administrators in the smaller hospitals. Meals, laundry and automobile expenses were the perquisites most commonly reported. However, four of the administrators in the smaller hospitals live in homes furnished by their hospitals. One administrator reported that the hospital gives him his "house and all utilities, meals, laundry, Blue Cross membership, Rotary dues, car expense and a yearly bonus." Another reported an annual bonus that amounts to 1 per cent of his salary during his first year on the job, 2 per cent the second year, and so on up to a maximum of 10 per cent after 10 years.

Only one administrator in the group reported that the hospital pays the premiums on his life insurance. As shown in the accompanying table, the average vacation allowance for the entire group is two weeks; individual administrators, however, especially in the larger hospitals, reported allowances of three and in several cases four weeks.

The survey was conducted anonymously in a Southern state; questionnaires were returned to state association headquarters unsigned and, in fact, administrators were urged to mail the questionnaires from post offices other than their own, in order to avoid any connection between the information submitted and the reporting hospital.

"The survey is undertaken in order to assist you in having more information at your command which might help you secure a more equitable salary," said a communication from the association to administrators, accompanying the questionnaire. "Your council is seeking statistical data for your benefit, not facts on your personal lives."

Salaries reported in this survey were 20 to 25 per cent higher than those reported for the same region in a survey made by The MODERN HOSPITAL four years ago. At that time, administrators of Southern hospitals of fewer than 50 beds reported annual salaries of $4140—slightly less than the salaries reported by administrators of 25 bed hospitals in the current survey, and 25 per cent less than the current group in hospitals of 26 to 43 beds.

In the 1952 survey, administrators of hospitals in the 51 to 100 bed group in this region were getting $5166, compared to $6170 for administrators in the 44 to 67 bed group in the current survey, and $7200 for administrators in the 68 to 84 bed group.

These differentials remained about the same for all size hospitals covered in the two surveys. The average salary for administrators of all hospitals in this region in the 1952 survey was $5355; in the current survey it is $7764.

Hospitals throughout the United States were covered in the 1952 survey, and the salaries reported for the South were the lowest of any of the eight regional groups included, it should be noted.

As in the present survey, the 1952 report showed a substantial percentage of administrators were receiving perquisites in addition to their cash salaries, with the greater perquisites in the smaller hospitals.

Columbia Offers Correspondence Course for Administrators of Small Hospitals

NEW YORK.—A correspondence course in hospital administration for executives from small and medium sized hospitals was announced here last month by the School of Public Health and Administrative Medicine of Columbia University.

Established with a grant from the Kellogg Foundation, the program aims to give persons already active in the hospital field an opportunity for systematic, long-term study of hospital organization and management, the announcement said.

TWO COURSES OFFERED

Two courses of study will be offered through the new Program of Continuation Education, under the direction of Harold Baumgarten Jr., assistant professor of administrative medicine, who was formerly manager of the hospital relations division of the Blue Cross Commission.

The first course will begin next June 1, and is planned for administrators seeking to broaden their knowledge of basic hospital organization and management.

The second course, scheduled to start later in 1957, will be limited to administrators with experience and will constitute "an intensive study of major problems facing the hospital field," the announcement said.

Both courses will be offered only to hospital executives in states included in the New England and Middle Atlantic Hospital assemblies, it was explained.

The course will last approximately a year, with students spending two short periods at the university, and receiving study materials at home for the remainder of the year. "Thus participants can retain their full-time positions in hospitals and complete the necessary assignments at home," Mr. Baumgarten said.

In addition to Mr. Baumgarten, other faculty members for the program are Dr. Ray E. Trussell, executive officer of the School of Public Health and Administrative Medicine, and Dr. E. Dwight Barnett, professor of administrative medicine.

An advisory committee has been organized to guide the program and consult with the faculty, it was explained. The advisory group is headed by George Bugbee, president of the Health Information Foundation and former executive director of the American Hospital Association. Members of the committee include some of the leading hospital administrators from the New England and Middle Atlantic states.

The course in hospital organization and management will cover study in five areas, the university said. These are: (1) purpose and function of the hospital as a center for community medical services, (2) methods of operating hospital departments, (3) services offered by the departments, (4) hospital organization, and (5) management problems.

"This is not to be a means by which persons may enter the field of hospital administration," Mr. Baumgarten said, commenting on the continuation program, "nor is it a substitute for the graduate programs in hospital administration now available in various universities. Each applicant will be required to demonstrate previous hospital experience and his future intentions in the hospital field. No degree credit will be given."

You, Too, Can Grow Your Own Employes

This hospital has found that a course which permits young people to get the feel of the field while they are still in school is an excellent means of recruiting and good public relations

NATHAN BUSHNELL III

THE acute shortage of nursing and technical personnel is no novelty to any hospital. All of us, small and large, share the problem; but it seems to me the problem is more serious in the small rural hospital than it is in the large urban institutions. The loss of one technician, one anesthetist, one dietitian, or any other one person can generally be absorbed in the larger institution, but in the small hospital of the rural areas, it can be a crippling blow to the over-all operation.

Of mutual concern to all of us in these small rural hospitals, in addition to the shortage itself, is the fact that there has been little we could do about it in a positive manner. True, we have our classes for nurse's aides, and many of us actively recruit student nurses, or perhaps even give the added incentive of offering scholarships, but when the facts are squarely faced, we must admit that the majority of us are fighting a constant, sometimes desperate battle to lure, or buy, graduates from our larger neighbors. Perhaps we might even be regarded as subtle, albeit, unwitting parasites. Such soul searching by many of us in the small hospitals has led inevitably to the same conclusion, and the same hand-wringing cry of despair, "What else can we do?"

Mr. Bushnell is administrator, Franklin Memorial Hospital, Rocky Mount, Va.

HOW THE IDEA CAME

The glimmer of an answer to the question came to us last year under not too unusual circumstances. One of the outstanding academic students of the local high school approached us with a request. He thought he was interested in going into medicine, and, to make sure, wanted the opportunity of working in the hospital after school

Young students at Franklin Memorial Hospital, Rocky Mount, Va., listen attentively as Nathan Bushnell III, administrator and director of the course, conducts a review of the lecture on the organization of hospitals.

hours in any capacity to "get the smell of medicine and hospitals." Following conferences with the medical staff, the high school, and the boy's family, we gave him an affirmative answer. He turned out to be most conscientious, tackling any job of orderly, circulating nurse, or janitor with equal vigor. Interspersed with a wide variety of working assignments, members of the medical, nursing and administrative staffs talked with this young man informally on numerous aspects of medicine and patient care. At the end of the school year his mind was made up: He has obtained a scholarship as a premedical student, and we are convinced he will survive the ordeal and emerge as an outstanding young physician.

During the same period we received similar requests from four other seniors interested in nursing, and one in x-ray. All five of these girls were anxious to obtain on-the-job training with us under the auspices of the DO-DE program (Diversified Occupation-Distributive Education), and were recommended by the counselor of this program. They too were accepted and received even more extensive didactic training than did our premedical student. At the end of the year, the x-ray student was accepted in an accredited school of x-ray technology and is even now doing exceedingly well and expected to graduate in half the usual time because of her training here. Tragically, of our four prenursing students who began so enthusiastically, only one was able to pass the pre-entrance examination of a near-by school of nursing. Investigation of their scholastic records, obviously a hindsight, revealed that all four were rather weak students, and could not have been expected to pass.

If we could influence three students into the medical field accidentally, why couldn't we accomplish far more with thoughtful planning?

Reflection on our year of fumbling in the field of "pseudo-education" brought the following three factors into focus:

THE MOST IMPORTANT POINTS

1. High school students are almost desperately seeking advice and frequently an opportunity to try out potential career fields.

2. In view of this fact, we and all other hospitals have a golden opportunity (let's say, obligation) to steer undecided and confused young minds into the medical and paramedical fields.

3. In our feeble efforts of the foregoing year we had committed three major errors of omission: (a) We had not properly evaluated those students who sought our aid, and had thereby largely wasted our time and theirs. (b) We had not sufficiently publicized the opportunities available in the medical and paramedical fields, and thus irrevocably failed to attract that year's crop of undecided and confused students. (c) We had not offered as good and comprehensive a course as we could have.

(*Continued on Page* 56)

Above: Mrs. W. G. Boyd (left), director of nurses, takes students on rounds and points out the technics of proper bedside care in her nursing course. Below: The lecture on anatomy and physiology, which is given by Dr. F. B. Wolfe, is very important to the students' understanding of medical care.

INTRODUCTION TO MEDICAL SERVICES

GENERAL INFORMATION

Courses will begin the third Monday in September and will conclude on May 31. Lecture classes will not exceed two hours each and no more than eight hours of lectures will be given during one week. Clinical work may exceed this time and a schedule will be arranged by the instructor.

Students must provide uniforms for clinical work as prescribed by their instructor.

Students maintaining a minimum average of 75 for the school year will receive a certificate at the end of the course. Students receiving conditional grades, 60 to 74, or others unable to complete their work for other reasons, may be retained in school following conference with their instructor and administrator.

REQUIREMENTS FOR ADMISSION

Any student between 16 and 25 years of age who has satisfactorily completed the sophomore year in high school with at least a "C" average is eligible for admission. Students must be reasonably certain of their desire to enter this type training, and must be acceptable to the department head of their specialty choice, and the administrator. They must have completed, or will be able to complete, those subjects in high school which are prerequisite to their acceptance in an accredited school of their choice. In most instances these will be biology, chemistry, algebra, and a foreign language.

COURSES AND CURRICULUM

All students will be required to attend the following series of lectures entitled "Introduction to Medical and Hospital Services."

1. Medical and hospital ethics.
2. History of medicine and hospitals.
3. Organization and tour of hospital.
4. Introduction to medical terminology.
5. Introduction to anatomy and physiology, in health and disease: (a) skeletal system, (b) muscular system, (c) cardiovascular system, (d) respiratory system, (e) alimentary system, (f) excretory system, (g) nervous system, (h) endocrine system, (i) reproductive system.
6. Physician-patient-hospital relationship.
7. The general practitioner, the specialists, and classification of patients.
8. Organization and function of nursing department.
9. Organization and function of dietary service.
10. Organization and function of laboratory.
11. Organization and function of x-ray service.
12. Organization and function of operating room, anesthesia service and central sterile supply.
13. Organization and function of delivery room and nursery.
14. Introduction to first aid.
15. Organization and function of medical records.
16. Medico-legal aspects of medicine and hospitalization.
17. Organization and function of housekeeping, linen and laundry departments.
18. Organization and function of maintenance department.
19. Organization and function of admitting office, and insurance procedures.
20. Organization and function of business office, including switchboard.
21. Hospital administration.
22. Examination.

Following completion of this phase of the course the student will then be assigned to her choice of the following departments.

NURSING

Curriculum: History of Nursing; Professional Relationships and Ethics; Nursing Arts; Nutrition in Health and Disease; Nursing Technics in Medicine, Surgery, Obstetrics, Pediatrics, Nursery and Communicable Diseases; Materia Medica.

LABORATORY

Curriculum: Laboratory Ethics; Doctor and Patient Relationship; Anatomy and Physiology of the Vital Organs and the Hemopoietic and Urinary Systems; Basic Procedures in Urinalysis, Hematology, Blood Chemistry, Parasitology, Serology, BMR, EKG; Preparation of Solutions; Use and Care of Equipment, Chemicals and Reagents; Nomenclature and Terminology.

X-RAY

Curriculum: History of Development of Roentgenology; Basic Chemistry and Physics of Radiology; Preparation and Care of Patient; Darkroom Chemistry and Technic; Care and Use of Equipment; Standard and Special Use of Diagnostic Radiology and Fluoroscopy; Reporting and Filing.

DIETARY

Curriculum: Familiarization With Equipment and Organization; Food Chemistry and Metabolism; Nutrition; Diet Therapy; Menu Planning; Special Diets; Experimental, Special and Quantity Cookery; Portion Control; Buying, Receiving, Inventory, and Issuing; Cafeteria and Tray Service; Cost Control; Personnel Management.

MEDICAL RECORDS

Combined course offered to students interested in medical records or medical secretarial work.

Curriculum: Reasons for, Purpose, and Arrangement of a Medical Record; Filing and Indexing Procedures; Use of Standard Nomenclature; Legal Aspects; Medical Terminology; Transcription; Statistics; Business Office Procedure and Use of Machines; Basic Accounting; Admitting Procedures; Hospital Insurance; Credit and Collections; Information and Telephone Switchboard.

(*Continued From Page* 54)

We resolved to correct these mistakes vigorously and positively by embarking on a broader program.

First, just how broad a course could we offer? Although our hospital had received full accreditation from the Joint Commission on Accreditation of Hospitals, the possibility of establishing any type of accredited training in a 52 bed hospital was out of the question. It could therefore be no more than an introduction, made interesting enough to stimulate a desire and ambition to complete education in an accredited institution. It would have to be good enough to prove of value to the students after they entered advanced training. It should be sufficiently comprehensive to embody all phases of the professional and technical fields within the hospital so that, should a student lose interest in one specialty, he might be interested in one of the other fields to which he had been exposed. Furthermore, the comprehensiveness would give the students an over-all appreciation of the complexities of hospital administration, of which the average hospital employe, or physician, has little conception.

DEPARTMENT HEADS HELPED

Without the cooperation of all our department heads, upon whom most of the teaching would devolve, our plan would be worthless. At a regular departmental meeting, the plan and its potential were presented. It was received with some skepticism and a few groans in anticipation of the additional study and work which would obviously be necessary. In general, however, all were enthusiastic, and excellent suggestions were offered and incorporated. Every department head and virtually every technician and R.N. in the hospital has taken an active part in planning and conducting the course. Without this wholehearted help, the plan would have been a dismal failure. Likewise, it received enthusiastic approval of the medical staff. Each member offered to help, and all have subsequently given lectures.

Following these conferences with the future "faculty," the theory and objectives were discussed with officials of the local Franklin County High School, and Ferrum Junior College, located 11 miles away. Both were enthusiastic and had constructive suggestions to offer. We were more than pleasantly surprised when the college requested permission to offer our course to its students with full credit, under the auspices of the general science course. Unfortunately, the plan was discussed too late to be included in the school's catalog, and too few students were able to include it in their curriculum to justify the transportation problem. The interest evidenced by the student body since the beginning of the school year, however, indicates the probability of our having several college students next year.

Discussions with our board of trustees, which approved the plan, numerous civic leaders, and parents were carried on concurrently with the talks with the school officials. The same questions requiring the same answers were raised repeatedly, and as our plan crystallized, we reduced it to a written outline. This was widely distributed to the board of trustees, medical staff, college, high school, and civic leaders throughout the county. It was also modified into a front page story by the *Franklin News Post,* our local weekly. Excerpts from this outline are shown on page 55.

Miss Jamie Muncy (right) chief x-ray technician, adjusts equipment while a student positions the patient for x-ray. Within two months students take responsibility for practically all routine chest films, from "snapping the picture" to turning over the finished product to the radiologist, after which the student transcribes the doctor's report on his findings.

GOOD TEXTBOOKS NEEDED

During the summer months and concurrently with many of the activities previously described, we purchased a 16mm. movie projector and screen, ordered numerous training films, acquired anatomy charts and a blackboard, and set up a classroom. Lectures were scheduled, and outlines were prepared. One of our biggest problems, which still isn't completely resolved, was that of procuring satisfactory textbooks. With such a modified course as ours, it seemed unreasonable, even imprudent, to use college texts; yet, it has been exceedingly difficult to locate any more basic ones.

We have been unable to find anything less than a tome which would

Patricia Etzler (right), chief laboratory technician, teaches the student basic laboratory procedures. Within three to six months the student can do many procedures under close supervision.

The student (left) who is specializing in dietary service learns some of the fine points of special cookery from Mrs. Mary Wright, assistant dietitian. She also obtains practical knowledge of quantity cookery from Helen Preston, the chief cook, shown in the background. Dietary students are taught nutrition, food chemistry, portion control, purchasing practices, and personnel management.

cover the "Introduction to Medical and Hospital Services." Even these do not include anatomy and physiology, which we feel are essential, since the prime objective of everyone in the hospital is healing the sick or injured bodies or minds of our patients. To overcome this major obstacle, each lecturer has been requested to draft a three to five page outline of his subject. Stencils are being cut on each of these, and shortly we hope to compile our own text of this all-important phase of the curriculum.

As we had anticipated, students in the grip of summer activities and a natural apathy toward education evidenced little interest in the course, and only three enrolled during the summer. For this reason, plus cognizance of the confusion which naturally exists during the opening school days, we postponed our opening until two weeks later. During this period, school teachers and counselors made the students aware of our course, and we interviewed nearly 30 with parents.

Our biggest single problem is scheduling. In order to avoid conflict with the school schedule, it was necessary for us to schedule our class to begin at 3:30 p.m., after the close of school. This eliminated most of our applicants for numerous reasons: It conflicts with many extracurricular activities such as athletics, cheerleading, band practice and school club meetings, and it eliminates all those county children who are dependent upon school bus transportation. All children are mentally and physically fatigued at the end of the day, especially those carrying a heavy academic load.

NO STIPEND OFFERED

Another deterring factor is that we are not offering any stipend for the "work," as is done by other concerns participating in the DO-DE Program. This is a big inducement and ofttimes a necessity for some of the students whose families are in financial straits. Our motives are largely altruistic. Although we hope eventually to profit by our efforts, we are now primarily interested in doing everything possible for the students—and exploiting them as cheap labor is neither in their best interest, nor ours.

Several parents, seeing the potential benefits we were offering, attempted to persuade their children to give up conflicting athletics or music lessons, but fortunately none did. Our course is, indeed, potentially valuable, but so is a well rounded athletic and social life. In our judgment, the course would lose much of its effectiveness if a student were compelled to drop other activities against his will.

These various obstacles narrowed our applicants to 10, and three of these did not meet our scholastic requirements. Our remaining seven are now in the specialty of their choice: four in nursing; one in dietary; one in laboratory, and one in x-ray. All are alert and applying themselves diligently. There has been no evidence of waning interest; if anything, it is increasing, according to reports from the parents. And from these reports comes evidence of another intangible benefit for which we had hoped: With their newly acquired knowledge, they are seven of the best public relations agents any hospital could ask for.

There are yet many unsolved problems, and when these are resolved there will undoubtedly be more to take their place. We do not presume this to be the panacea which will erase the hospital personnel problems of the nation overnight; but, it is an experimental step which can be taken by any small hospital. If enough do take it, within a few years it is quite conceivable that it would have a marked effect in reducing the shortage. To us the potential benefits, even if we never reap them directly, are worth far more than the time, effort and money they have cost.

The Trouble With Nursing? No Nurses

An "escalator program" that gives the first-year nursing student all the work needed to qualify her as a licensed practical nurse might salvage many "dropouts" who would otherwise be lost to the field

LESLIE D. REID

MUCH has been written and even more has been said about the most basic factor in hospital service: What's wrong with nursing?

It is so easy, and such a common fault, to think that everything and everybody connected with hospitals should change, but not the nurse. This, however, overlooks the basic fact that inside the white uniform is a typical American girl drawn from the upper third of her high school class, whose economic, personal and cultural traits provide her with the same basic desires as her associates and friends outside the nursing field.

HAS TO FACE REALITY

Although initially the nurse may have a sense of calling to this noble profession, she finds herself having to adapt her life to its unchanging demand of the patients' needs for 24 hour a day service. If she cannot so adjust and still live a normal life, her personal desires take precedence even though the primary interest that attracted her to hospital bedside nursing continues.

To try to bring into focus all of the elements involved in nursing in order to get an immediate and reasonably accurate answer to our initial question is like looking into a kaleidoscope. Everytime you change the relationship of some of the aspects of nursing, the future picture changes and the question must be answered from a different approach.

In this article I shall bring into focus some of the elements involved in this ever changing picture of nursing and then draw some conclusions from this complicated problem.

The five major demands for nurses, namely, private duty, public health, the veterans' hospitals, industry, and the doctors' demands, all of which have become so great in the last few years, would in themselves have created a nursing problem today, all other things being equal. Hospitals that run schools of nursing must recognize that they are now engaged in an area of education that goes beyond the basic idea of meeting their own staff needs. We are constantly reminded of this in the ever rising standards and the broadening of the educational program of the student.

As if these factors were not enough, a far greater strain has been placed upon the available nurse power by the rapid increase in hospitals throughout the country, as well as the many additions to already existing facilities. This impact and its consequent strain upon the hospitals operating schools of nursing to keep up with the demand is best shown in Table 1 on page 59.

In this short 10 year period from 1946 through 1955, the number of hospitals has increased 831, or 13.5 per cent. While beds added in this same 10 year period showed an 11.7 per cent increase, the number of admissions increased 34.4 per cent, not including births, which showed an increase of 62.8 per cent. This phenomenal growth in admissions resulted in an increase of 221,160, or 19.3 per cent, in the daily census of patients. The 1950 figures show increases over 1946, except for number of hospitals, that are about halfway between the increases in the 1946-1955 period, indicating a consistent growth. If this growth continues in the years ahead, even though at a less accelerated rate, the problem of providing graduate nurses will become greater.

THERE ARE OTHER COMPLICATIONS

This increase in hospitals, beds, admissions, average daily census, and number of births would be more than enough to tax the nursing resources even if other changes had not taken place. Along with this growth a further complicating factor has been added in the last few years with the general adoption of the five-day 40 hour week for graduate nurses as well as other personnel. The sheer reduction from a six-day work week to a five-day week would require an increase in nurses of 16⅔ per cent to provide the same volume of care. This same reduction in hours has spread to the student nurse and, as would be expected, the decrease in hours has been on the service side of the students' training.

The change in hours was inevitable and could not be delayed. It only points up a further complication that has appeared in the problem of stretching the available nurses to cover the patients' needs.

In this same comparative period the changes in the number of schools of nursing and students are shown in Table 2.

The figures for students graduated for 1946 cannot properly be compared with the other two years because in 1946 we were still operating under the stimulus of the cadet nurse program. A comparison of 1950 and 1955 would seem to indicate that some progress is being made in the number of students

Mr. Reid is administrator, St. Luke's Hospital, Kansas City, Mo.

graduated, although the plain fact is that in 1955 there were graduated only 4.10 nurses per hospital. If these 4.10 nurses were placed on a five-day, 40 hour week, this would reduce the number available per day to 2.92 per hospital in order to cover each 24 hours in a seven-day period. This is slightly less than one nurse per eight-hour shift per hospital. This figure is undoubtedly overstated by as much as 100 per cent since perhaps half of the graduates soon find employment in fields other than hospital work or get married. Therefore, a more realistic figure of replacements in 1955 would likely be 1.5 nurses per hospital. Certainly it must be agreed that this is not nearly enough to ensure adequate bedside nursing care by graduate nurses. The fond hope that the nursing problem will be met by registered nurses is only a mirage.

What is the commonest question asked when administrators and directors of nursing get together? "How do you staff your hospital on Saturday and Sunday, evenings and nights?" This question goes begging for an answer because now some 60 per cent of all the active nurses are married, widowed or divorced. With the general acceptance of Monday through Friday as the work week, married nurses are willing to work those day shifts, but not nearly so willing to work week ends or the evening and night shifts. This is understandable if married nurses are to maintain their households. One would hope that the profession of nursing would solve the problem, but realistically the profession is made up of individuals and, therefore, not able on a collective basis to bring about adequate staffing in the difficult periods.

Table 1—Comparison of Hospitals, Beds, Admissions and Census

	1955	1950	1946
Number of hospitals	6,956	6,788	6,125
Number of beds	1,604,408	1,455,825	1,435,778
Number of admissions	21,072,521	18,483,185	15,674,602
Average daily census	1,363,024	1,252,831	1,141,864
Number of births	3,476,753	2,742,780	2,135,327

Table 2—Changes in Number of Schools of Nursing

	1955	1950	1946
Number of hospitals	6,956	6,788	6,125
Number of schools	1,139	1,170	1,271
Number of students graduated	28,539	25,790	36,195
Number of students admitted three years previously	41,667	38,210	53,074

Table 3—Accreditation Status of Schools of Nursing

	Per Cent of Schools and Status of Approval	Per Cent of Students Enrolled
Fully approved	22.2	36.8
Temporarily approved	56.5	52.2
Not approved	21.3	11.0
	100.0	100.0

HOSPITALS CARRY BURDEN

Hospital schools of nursing have carried the major burden of educating nurses, but, like all professions, the standards are being raised to the point where nursing schools are becoming quite costly to operate. A great deal of encouragement has been given to collegiate schools by the nursing leaders and by the discouragement of diploma schools in the face of rising standards.

Table 3 shows the status of schools of nursing regarding accreditation status and per cent of students enrolled:

The fact that only 22.2 per cent of the schools, with 36.8 per cent of the students, are fully approved is discouraging to the other schools as they have in their own way tried to render a most important service. This is a relatively poor showing for the time, effort and money that have been expended by hospitals to create the nurse, who is the very center of patient care. This is the product those of us who run schools have spent the most to produce.

Tabulated here is the status of schools as they have decreased in the five-year intervals shown:

1935	1472
1940	1311
1945	1295
1950	1170
1955	1139

The April 26, 1956, bulletin of the National League for Nursing indicates that the schools have decreased further to 1125.

Fortunately, student enrollment has been fairly well maintained by the decreasing number of schools during the five-year period from 1950 to 1955, but with some marked change as between diploma and degree students, shown in Table 4 on page 60.

This increase in students in the collegiate program is in line with the efforts being made in the profession to upgrade the educational experience of the student. It seems certain, though, that the collegiate trained nurse will not provide the bedside nursing in the future that doctors, administrators, directors of nursing, and the public are so constantly seeking. If they were to provide the educational staff for the diploma schools to ensure their continuance with well trained faculty, this increase would be fortunate indeed. We cannot overlook the fact that this increase in the degree program may be but a part of the general economics we now enjoy. One has reason to be greatly concerned about the problem of educating bedside nurses every time a diploma school closes. Hospital administrators must be concerned with this even more than nurse educators, because they are charged by their boards and the public which gave the money to build the hospitals to use proper judgment to staff them to provide adequate care.

One can therefore properly ask: "Why build more hospitals and add

Table 4—Comparison of Diploma and Degree Students

	Number of Students Enrolled		
	1955	*1950*	*Increase (Decrease)*
Diploma students	92,583	93,325	(742)
Degree students	14,989	9,184	5,805
	107,572	102,509	5,063

Table 5—Number of Students Enrolled

Enrollment	*Number of Schools*	*Students Enrolled*	*Per Cent of Schools*	*Per Cent of Students*
0- 49	272	8,433	23.9	7.8
50- 99	457	32,421	40.1	30.1
100-149	234	28,640	20.5	26.6
150-199	98	16,666	8.6	15.5
200-249	44	9,821	3.9	9.1
250-299	15	4,103	1.4	3.8
300-349	8	2,586	.7	2.5
350-399	5	1,884	.4	1.8
Over 400	6	3,018	.5	2.8
	1,139	107,572*	100.0	100.0

*Of the 107,572 students in training, 92,583 are in diploma schools.

Table 6—Number of Drop-Outs in Schools of Nursing

Year	*Graduated*	*Admitted Three Years Earlier*
1954	28,539	41,667
1953	29,308	44,185
1952	29,016	43,612
1951	28,794	43,373
1950	25,790	38,210
	141,447	211,047

more beds in face of the fact that we only graduated in 1955 the equivalent of 2.92 girls per hospital?" The national average of nurses in training shows there is one nurse in training for each 12.5 patients, on an average, in our hospitals each day, while some representative states show the following averages:

One Nurse in Training

(In relation to average number of patients hospitalized daily)

Total United States	12.5
Minnesota	7.3
Pennsylvania	8.3
Kansas	9.3
Missouri	10.9
Illinois	13.3
Michigan	14.1
Texas	17.4
New York	17.4
California	24.0

It is apparent that the hospitals in some states, and notably Minnesota, are making a real contribution to helping provide nurses. It is equally clear that other states are depending on others to educate the nurse, hoping that by climate, salary and so on, they can entice nurses to migrate to their state. Up to this point, at least, the voluntary hospital has carried the brunt of the educational program for the nurse. If this is to continue, and if, in true American tradition, education at all levels is to remain the responsibility of the local community or the individual states, then hospitals as individuals will have to reassess their obligation to themselves and to their community and state. Here is an excellent opportunity for state hospital associations to take some real leadership in establishing schools where they are needed and strengthening those that need assistance.

The addition of beds to hospitals without schools and the building of new hospitals only adds to the burden. Greater effort to produce more nurses must be made by each state and especially by those states that are deficient in relation to the national average of nurses in training in comparison to their average daily census of patients.

A tabulation of the schools of nursing by the size of enrollment (Table 5) points up that by far the largest number of schools have fewer than 100 students enrolled.

These figures show clearly the importance of the schools of nursing in hospitals with fewer than 100 students and the contribution they are making in the education of registered nurses today, inadequate as the total effort is in comparison to our needs. Students in these schools constitute 37.9 of all students in training. With 729 schools in hospitals with fewer than 100 students, which is 64 per cent of all schools, there are in training 40,854 students, which is 44.1 per cent of the total students in diploma courses. The average number of students in these 729 schools is 56.

WILL CREATE MORE PROBLEMS

If the education of the nurse has moved into the area where schools with fewer than 100 students find it difficult to meet the standards of accreditation, and because of inadequate facilities and for other reasons fall by the wayside, some alternate program of nurse education must be developed. This is a serious problem which if allowed to continue will only create more acute problems in nursing in the future. The many large hospitals that do not operate schools are greatly indebted to those hospitals that tenaciously hold to the tradition that they should operate schools of nursing.

It certainly cannot be argued that all schools now in existence should be continued because some standards must be set. One can only point out that if hospitals are to continue to train the nurse for bedside care the larger hospitals must accept a greater responsibility by enlarging their schools or establishing them where they do not exist. It is difficult, if not impossible, to imagine the colleges taking over this problem to the degree necessary to provide sufficient bedside nurses for all our hospitals.

During the five-year period we have graduated 141,447 nurses out of 211,-

(*Continued on Page* 140)

What Kind of Services Shall We Plan for the Aged?

In the following pages, The Modern Hospital presents three answers to this challenging question—results of a design competition on Homes for the Aged (page 62), some down-to-earth observations by the wise operator of a successful nursing home business (page 65), and a picture-story of an ideal home (page 69)

". . . at a great old age, without leaving any regrets behind"

Our goal for the elderly is to plan for them so well that they will be able to die peacefully, in sleep, at home, at a great old age, without leaving any regrets behind. Planning of this kind must take into consideration the relative responsibility of the family and the community. Subsidy must be equal to the varying requirements of misfortune. Progressive loss of physical strength must be understood in relation to a competitive world, and exemptions granted accordingly. Mental senility must be faced squarely and dealt with humanely. The tragic story of memory and its decline must be dealt with sympathetically. Freedom from fear is of particular significance to the elderly, and this is true in varying degrees for those who are blessed with friends as well as for those who are friendless. In particular, we must avoid pursuing easy ways for solving the problems of the elderly. Among these is the institutional remedy applied in the absence of a skilled diagnosis or the presence of a snap prognosis.

Science and humanity both play vital rôles in planning. We must not expect too much from rehabilitation programs, remembering that productivity parallels ability more than willingness. The value of maturity and experience, which accompany age, must receive greater recognition and greater respect from youth.

Preparation for the inevitable hour spreads over a complete lifetime but, above all, we must remember that every life that is lived is an experimental life, calling to us to do or not to do in accordance with the success or failure of these lives.

E. M. BLUESTONE, M.D.

Jury Selects the Best Designs in Competition on Homes for the Aged

The first prize winner has "logic and clarity" and suggests space that is not only pleasant to live in but easy to supervise and administer, the judges explain

WHAT kind of facilities shall we plan for the aged? Dr. Bluestone's suggestion (see previous page) that "our goal is to plan so well that they will be able to die peacefully, in sleep, at home, at a great old age, without leaving any regrets behind" must seem visionary as we contemplate the problems of a society in which 1000 men and women every day reach the age of 65—many of them without homes or families or funds and requiring care of physical ailments and understanding of mental foibles.

To help organize our thinking and resources for the gigantic task of planing a way of life for the homeless aged, the National Committee on the Aging of the National Social Welfare Assembly last year sponsored an architectural competition in the design of a Home for the Aged, including a 25 bed nursing unit and accommodations for 75 ambulatory residents. The competition was conducted under a grant from the Frederick and Amelia Schimper Foundation, with the cooperation of THE MODERN HOSPITAL and *Architectural Record*.

In the words of Pietro Belluschi, dean of the School of Architecture and Planning at Massachusetts Institute of Technology, who was chairman of the jury which reviewed nearly 200 plans submitted in the competition to select the award winners, "The results were judged by the usual architectural standards, but they must also be viewed in a much larger social context. Architects, particularly the younger ones, take pride in the fact that they are becoming more aware of human and social values. They believe that if their profession has made contributions of any great value to our present civilization, it has not been in erecting monuments or palaces or cathedrals or grand-scale city plans, but in creating establishments for the use and comfort of the average human being."

TERMS OF COMPETITION

Terms of the competition, as reported initially in THE MODERN HOSPITAL last spring, presented a clear-cut problem. In addition to the stipulation that the home was to be designed for a total of 100 residents, with the necessary supporting services for its nursing and residential units, the home was to contain certain "health maintenance facilities," including a doctor's office with adjacent examining room, laboratory for routine blood and urinalyses, EKG and BMR room adjacent to the laboratory, dental room, EENT examining and treatment room, radiographic suite, doctors' lounge and locker room, and physical medicine suite. The physical medicine suite was to include an office for the chief therapist, graduated workshops for occupational therapy, exercise room, electrotherapy booth, hydrotherapy booth, and appropriate areas for portable equipment and supplies.

Residential rooms were to be planned to permit at least two furniture arrangements, one with the head of the bed against the wall and 3 feet of access space on either side to permit ease of bed care when required. In addition to the residents' rooms, residential areas were to include appropriate living rooms, porches, terraces and service units, including a nurses' station with charting space, medicine preparation and storage space, utility room, and bedpan washing facilities.

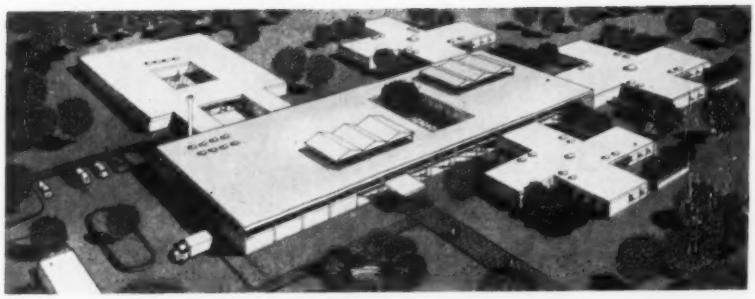
Contestants were free to select their own sites, which could be in either urban or suburban areas, in small or large communities, anywhere in the continental United States or Canada. It was suggested, however, that wherever possible site selection should be based on a real piece of property suitable for a home for the aged.

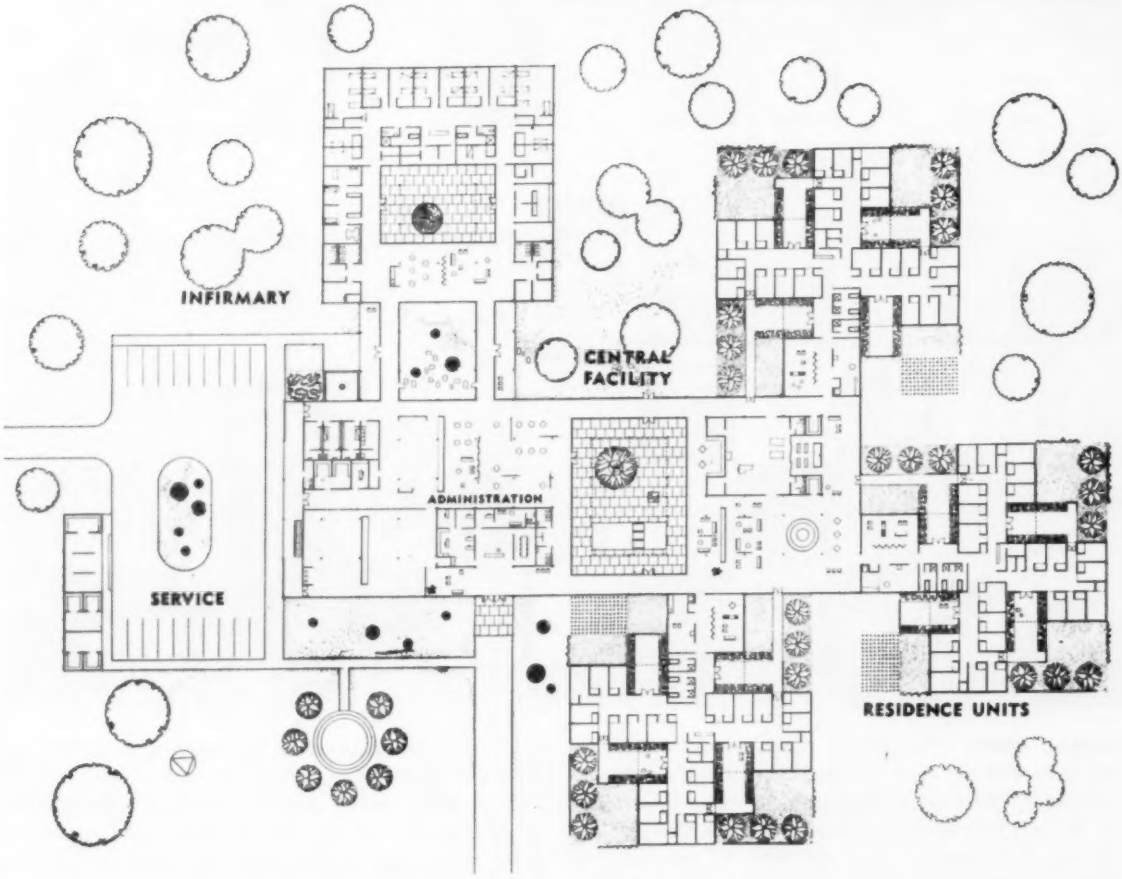
Notwithstanding the precision of the competition's details, the complexity of the problem as it exists in real life is suggested in one of Mr. Belluschi's comments: "The competition has given us a glimpse of the many ways in which the problem can be met, and perhaps even more has shown us the necessity of defining its limits. The architects who will be asked to design these homes in the future must be told clearly for whom they are to build —that is, how old are the persons to be housed, what kind of care should they receive, how much freedom should they have?

"Someone must decide how much our society can afford to do. Should we attempt to make it so easy and attractive for men and women of minimum social security age to live in such ideal conditions that all our resources will be exhausted before we can take care of the older and more

(*Continued on Page 64*)

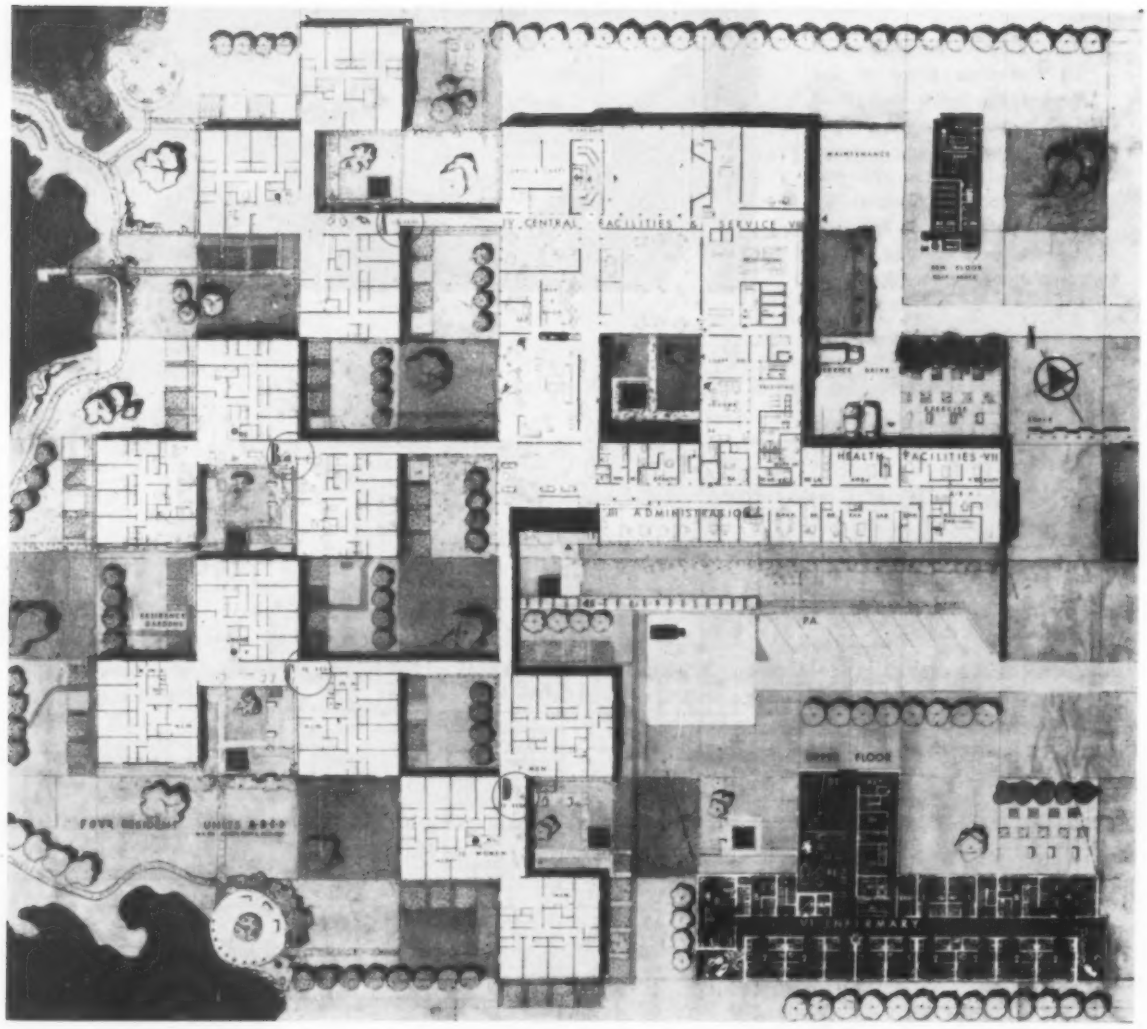
Right: Exterior perspective of the first-prize entry in the competition for a design of a home for the aged, including a 25 bed nursing unit and accommodations for 75 ambulatory patients. Below: Plot plan showing the building on the site and relation of the components of the home.





Below, left: Two-bed infirmary room with adjoining toilet facilities. Right: Single room for an ambulatory resident.

FIRST PRIZE. The winning design in the competition for a plan of a home for the aged by J. J. Jordan and Hanford Yang of Philadelphia was the unanimous choice of the jury of experts who made the selections. "It seems to combine in a rare and self-assured manner the best qualities of all other entries," the jury stated. "The plan has logic and clarity; it suggests space pleasant to live in and easy to supervise and administer. The clinical facilities, although separate, are convenient and well located in relation to the administrative unit. The recreation area is in a most appropriate relationship to the living units; these in turn have been so designed as to create a gracious environment. The exterior design is restrained yet warm, appropriate without affectation, depending on good relationship of spaces and on the garden-like courts to obtain a homelike effect rather than on superficial or fashionable tricks."



SECOND PRIZE. The project which placed second in the home for the aged competition, entered by Alfred and Jane West Clauss, Wallingford, Pa., was thought by the jury that reviewed plans to possess many of the virtues of the first award. "Although its plan has less clarity and the circulation is not as good," the jury said, "the layout of the infirmary is very efficient, perhaps more so than is the first prize, yet it is not so accessible to the administration or to the services, even if a case can be made for placing it on the second floor. Of the two or three similar schemes having clustered living units, this was not the most brilliant from an esthetic point of view, but was the most easily defended in terms of circulation and relationship of the units to the intervening courts. The exterior design was good even if a little self-conscious in the treatment of roofs."

(*Continued From Page 62*)

helpless cases? Should we think of them as people beginning a new and more sheltered life, where all the opportunities of social contact are preserved and even enhanced, or are we to give more weight to the ones who need protective and health care?"

These are not idle questions, Mr. Belluschi added, because the answers will directly affect the selection of site, the expenditure of sums, the size of the establishments, and the design of plans and details of the buildings we provide for our aged population.

Prize-winning plans, together with excerpts from the jury's comment on the plan in each case, are presented in these and following pages. In addition to Mr. Belluschi, members of the jury were: Ollie A. Randall, chief consultant in services for the aging, Community Service Society of New York; Dr. Charles F. Wilinsky of Boston, hospital consultant and former administrator, Beth Israel Hospital; William W. Wurster, dean of the School of Architecture, University of California; and I. S. Loewenberg, architect, Chicago.

Edward H. Noakes, a member of the Washington, D.C. architectural firm of White, Noakes and Neubauer, was the consulting architect for the competition, and Mr. Loewenberg served as professional adviser.

The Only Good Program Is One That Works

Several cherished theories of nursing home planners are politely but firmly demolished by a man who has learned from experience that, attractive as they are on paper, they just will not work in actual practice

BERT H. COHN

IT IS interesting and, I must admit, often exasperating to go over some of the plans for model nursing homes such as have been drawn up by able architects and even presented to us by the government. I would like to call attention to some of the points at which such plans have proved impractical because they have all too evidently not been based on realistic experience.

I am not an architect. I speak only from experience gained through owning and operating both a large and a small nursing home. Our large home cares for 130 residents and has a staff of 51; the smaller home cares for 30 with a staff of 15. I am thus familiar with problems in the field—from actual experience—and it is from that actual experience that I speak. The lack of such experience seems to me to be far and away the worst fault to be found in the drafting of nursing home plans. In one plan after another, this lack of knowledge of practical considerations in the handling of the aging is very evident. I have no wish to deride plans or planners. I only wish to help make nursing homes better by offering what I have learned.

Mr. Cohn is the owner of Washington Springs Nursing Homes, Inc., Okawville and Benton, Ill.

This article was condensed from a paper presented at the meeting of the American Association for Hospital Planning in September 1956.

NOT THE MOST DESIRABLE SIZE

In the first place, I do not consider the home of 25 to 50 beds to be the most desirable size. It has frequently been stated that homes larger than this lose their "homey" atmosphere. This need not be so. Size alone makes it neither a home nor an institution. In a home the size of our large one (130 beds) the personal touch need not be lost, and is not. The general condition of residents in mind and body, the conditions of rooms and halls, and the quality of care being given can be noted during daily visits and those little chats themselves do much to maintain the close touch and individualized service so necessary to the morale of patients and the efficiency of employes.

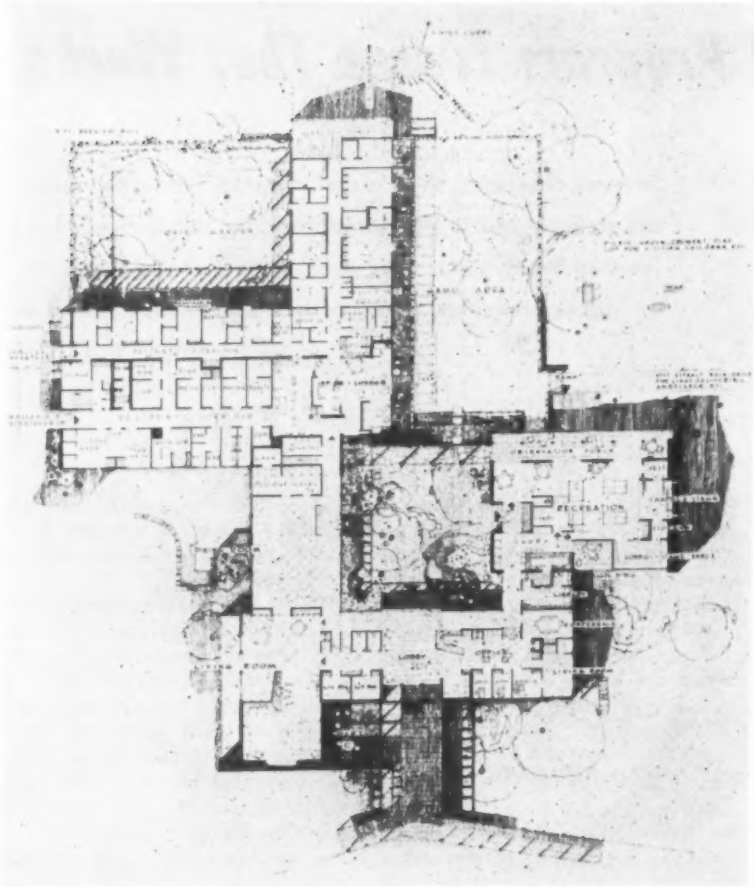
We do agree with the planners who advocate keeping patients of similar types together. In our larger nursing home we have three sections with four divisions. Those who are ambulatory, mentally alert, and pretty well able to care for themselves are located on the first floor. They may need some assistance with dressing, such as combing hair, tying shoelaces or neckties. They may need assistance into wheel chairs or be unable to cut their meat, but they are able to be up and about, to go out on the wide porches or use the long ramp to get into the yard. The first floor is run like a hotel, with nurses for bell-hops. Residents here are alert, interested in what goes on, enjoy the political campaigns, news events, TV, radio, baseball, and so forth.

There are many radio and TV sets on the second floor also, but residents

A resident of the Washington Springs Nursing Home, Okawville, Ill., reads contentedly in her comfortable room.

Occupational therapist supervises patients in the card and visiting room of the Washington Springs Nursing Home.

"MOST HOME-LIKE AND MOST LIKED BY THE INHABITANTS"



THIRD PRIZE. In the architectural competition for the best design of a home for the aged (see *p.* 62) this plan by Gerhardt Liebmann of New York City won the jury by its "charm and by the informal residential character of its parts," it was explained. While the administration of its living units would obviously be made difficult by their separation and distance from the main building, the jury felt that "in this case and other cases where site and climate are favorable, such difficulty may be justified by the desire to provide smaller, more intimate and even less institutional grouping of residents' rooms. The jury also recognizes that some efficiency and clarity of circulation in the central building were somewhat sacrificed in order to obtain such pleasant surroundings."

here need more care and attention. Some must spend much time in bed or chair, need more help with dressing, walking and other functions. Some are incontinent and there are more behavior problems. The more senile and confused are placed at one end of the floor, the alert at the other, thus making two divisions. Although there is no distinct dividing line and they visit with each other, we try to keep those requiring similar types and amounts of care together. To have patients who need frequent care widely separated makes much extra work for the nurses.

Our third division is the hospital wing where those who need maximum care and attention are placed. In all three divisions, emphasis is placed on grouping patients who are congenial. Where they have single rooms, such residents are in the same general area. In semiprivate rooms or wards, we try to match up patients with similar likes and dislikes, general background and outlook, so that one who likes the windows wide open is not paired with one who likes them closed, or the extremely religious person is not paired with the scoffer. After all, it is only practical to make patients happy; contented residents are less demanding and they are also your best advertising!

Before I go on to the consideration of other things, let me call attention to the desirability of porches. Wide, pleasant, open ones serve the double purpose of summer enjoyment and winter exercise for many. Enclosed porches for year-round use are fine, too, but nothing beats the roomy, open porch for pleasant, homey atmosphere. We know, for our larger home has them and the smaller one does not. Modern planning seems to overlook the many advantages of that real outdoor living room, the homelike, well railed porch.

We agree with planners that private and semiprivate rooms are most satisfactory, although we have a few wards of three and four beds, in which the residents are very happy. It depends on the individual and upon careful screening. Most older folk have grown somewhat rigid and set in their various ways and find it hard to adjust to others. Adjusting to one person is often problem enough, without trying to fit in any more. On the other hand, well matched roommates in small wards often find life much more interesting and enjoyable than do those in single rooms.

I wonder sometimes just how much of a handicap to practical planning it may be that the planner has not had enough contact with people in various walks of life and so knows very little about their modes of living. Plans seem to provide for people who are used to the niceties of life—people who belong to the upper middle class. Nursing homes care for the less fortunate as well, in fact for more who have lived simple lives in plain, even common, surroundings. Some have never been able to live well even had they been familiar with good standards of living; some who were able to do so still led frugal existences. In some of the plans that I have seen for nursing homes, these people would be out of place. I am trying to make the

point that the things which a planner might consider suitable for people in his own circle might not be useful or even appreciated by those whose limited lives he has not shared and does not understand. A middle-ground approach to the problems of planning a nursing home would be most practical.

It is assumed by most planners that dining rooms are highly desirable in a nursing home because of the companionship found therein. This sounds fine and should be so, but the fact remains that, human nature being what it is, things just don't work out that way. Too often that fine word "companionship" comes to mean the inevitable bickering that ensues when a group of elderly people of various walks of life and different likes and dislikes eats together three times a day. Older people are often insecure, easily hurt, possessive, jealous, neurotic, truly "twice a child." We find that tray service in their rooms eliminates many problems and irritations to the patients and staff.

As for companionship, why should a dining room be necessary for that even if the varying types of friction could be eliminated? Are there not recreation centers for such companionship? Are residents not permitted to visit in each other's rooms? If not, the place is truly an institution and not a nursing home.

The physical and mental conditions of the patients are another factor to be reckoned with in the use of dining rooms. Many are embarrassed to have others see their need for assistance with eating; others, suffering from senility, are often unappetizing table companions.

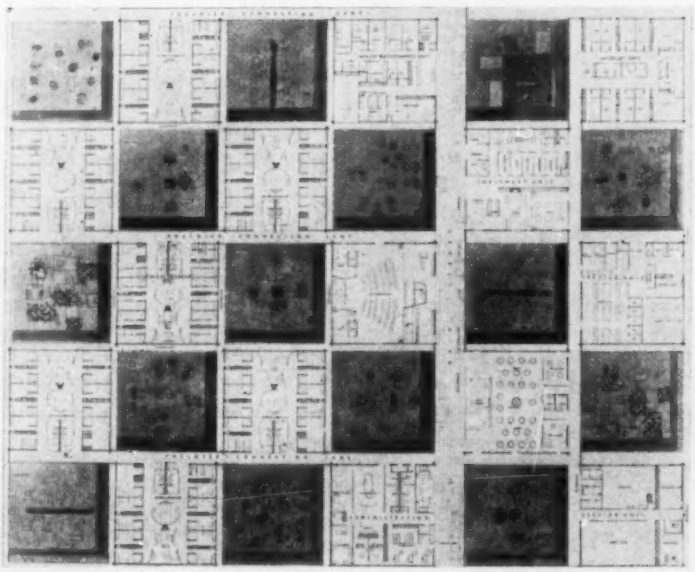
From dining to foods is a natural step and the kitchen is a vital part of the nursing home. We think that centrally located kitchens are the most practical, especially if located below the first floor. Hot foods may be sent up by dumb-waiter in food wells or deep wells, placed immediately in the warmers and kept piping hot while the entire floor is served. Diet kitchens on each floor are provided with such equipment as stove, refrigerator and commercial size toasters. Trays are set up and desserts are placed on individual plates just prior to the sending up of the hot foods. It is then a simple matter for three or four persons to serve the entire floor quickly and efficiently. Nurses and orderlies quickly speed the trays to the rooms in routine order. Exceptions are made in cases of slow eaters, who are served first. Food for patients who must be fed is sent up before the regular meal so that there is plenty of time for the feeding operation.

Our kitchen layout favors the long, wide table space in the center as the most efficient. There are two large stoves, each one opposite this table space. Refrigerators occupy a third wall, which also gives access to one cooling room and two of the food supply rooms. The fourth wall is filled by the specially built pot and pan cleaning area and the large dishwasher with more table and storage space adjacent to this center. Our food elevator is located at one side of the kitchen and quickly carries hot food to the diet kitchens directly above.

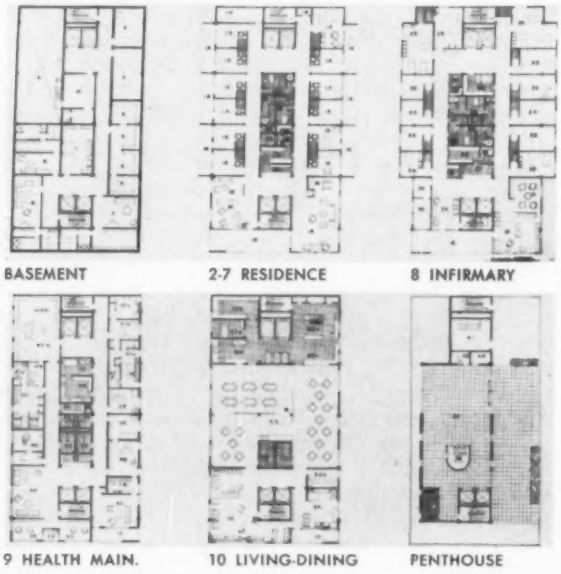
The chief cook prepares menus well in advance and as far as possible in accordance with the recommendations of good nutritional practice. Here is another area where the planning and the practical clash. For example, much emphasis is placed upon the serving of raw vegetables as in salads. We

"VIGOROUS AND SPIRITED TREATMENT OF COURTS IS FETCHING"

HONORABLE MENTION. The jury in the home for the aged competition (*p. 62*) debated longest on the checkerboard scheme proposed by the team of Katz, Waisman, Blumenkrantz, Stein and Webber of New York City. The committee reported: "It is a brilliant effort by talented designers. The serious objections raised by some members of the jury to the rigidity of this pattern may be met by the argument that, by using the same size units throughout, prefabrication is allowed and great economy is achieved. However, the general circulation to and through the units and relationship between parts and functions are so adversely affected by this arbitrary scheme that the jury as a whole could not bring itself to give it more than a 'mention.' The jury must add that much of the fetching quality of this entry was obtained by the ingenious and spirited treatment of the various courts as living and recreational units."



"THE BEST OF SEVERAL SCHEMES FOR A MULTISTORY BUILDING"



HONORABLE MENTION. One other plan selected by the jury in the design competition on homes for the aged described on page 62 was that entered by Norman H. Hoberman & John Gallegher, Cambridge, Mass. "It is the best of several schemes developed for a high-rise, multistory building. The plan is compact and efficient and it has attempted the difficult task in a tall building of providing a warm human environment. The jury liked the scheme in spite of the confused and fragmented exterior composition." In submitting its report, the jury stressed the fact that "much thinking has yet to be done on the problem of designing homes for the aged," but added: "We believe that these examples will serve as a stimulus and certainly as a starting point in our quest for the ideal solution to every case which shall come to all of us for solution in the future."

try to comply, with the result that a lot of good food is wasted. Many of our residents are of German extraction. They have never eaten raw vegetables. Many have never eaten raw fruits. They believe that raw foods in general are not healthful. With the exception of sliced tomatoes, cabbage slaw and garden lettuce wilted with sweetened hot vinegar, raw foods go practically untouched—and just what can you do about it?

Someone may tell you that you must "educate" your people. Try educating a 97 year old spinster who is still in excellent mental and physical condition, and who proudly tells you that she has never eaten anything raw in her life and is certainly not going to start now! Or "educate" another oldster who has never eaten *any* vegetable, raw *or* cooked! He says, "I got to be 92 without vegetables and without a doctor. I'm doing fine on meat, potatoes and fruit like I've had all my life. Don't give me any animal fodder. What do you want me to do—kill myself with that garden truck!"

In the practical operation of a nursing home the food recommendations of nutritionists and the food preferences of patients must be reconciled. We try to follow the recommended plans and we also bear in mind the general food preferences and favorite methods of preparation. Then we work out the menus in the best practical way. But I must admit that I marvel at the many "over-eighties" we have who are in better trim than their raw-salad eating sons and daughters! As one old fellow put it, "You just come around and talk to me when *you're 88,* if you're able, and we'll see then who's right!" The way he looks right now, he may very well be around when I am 88, too!

We prefer the downstairs location of kitchen, laundry, linen and sewing rooms, furnaces and all types of storage. For one thing, it separates the working areas from the patient areas and gives the workers in these utilities a chance to do their work without interruption. In their eagerness to help, old people sometimes get into trouble and separation of the work areas is one way of removing temptation.

Just as the food elevator takes care of the transportation of foods to the first and second floors, so does the laundry elevator carry the clean laundry to these floors. This elevator is never used for soiled laundry, which is sent down in special chutes from each floor into separate bins located in the laundry. Our laundry, which is operated seven days a week, has dual equipment —two 56 inch gas mangles, two electrical extractors, two 60 pound tumblers, and two 60 pound driers. Finished linens are sent up to the proper floor and placed in the linen closets ready for immediate use. Finished clothing is placed in the residents' lockers, dresser drawers, or closets. Linen and clothing which needs mending goes to the linen room or sewing room for proper attention.

After we accidentally discovered a nurse making a new dress out of a new bedspread and learned that she had already made up two pretty skirts out of a pink and a blue blanket, we made a rule that no new items would be issued unless the old was turned in. This not only eliminates possible pilfering but the worn items are immediately seen by the head house-

(*Continued on Page* 144)

Who Has More Fun Than Old People?

Those who live in the Mary Manning Walsh Home in New York City, at least, have all kinds of fun learning that, so far from being over, their lives are just getting off to a good start—at 70-odd

RAYMOND P. SLOAN

MRS. X, aged 74, is in business—the millinery business. You won't find her listed in the directory, nor is her shop on any one of New York's smart avenues. You enter a building on East 59th Street, facing the Queensboro Bridge, walk directly past the reception desk and head downstairs along a corridor until your attention is directed to a showcase. There they are —Mrs. X's latest collection, especially designed for residents of the Mary Manning Walsh Home.

Mrs. X herself is a resident of Mary Manning Walsh, one of 20 residences for old people operated by the Catholic Order of the Carmelite Sisters for the Aged and Infirm throughout the country, four of them in New York City. With some 50 men and 250 women, approximating 300 in all, ranging in age from 60 to 98 years and over, Mrs. X laughs at all the talk about the infirmities of old age. They don't have time to think about them. They're much too busy living what approximates normal lives in an environment cut to their particular pattern.

Like many others, Mrs. X first entered the home with mixed feelings of gratitude (there is always a substantial waiting list) and quiet resignation. It was the proper step to take; never, for all the world, would she become a burden upon her married son. Fortunate to be admitted to the home, there were adjustments to make nevertheless—serious adjustments from years of complete independence—to institutional living.

Under the shade of an umbrella, on the roof of the Mary Manning Walsh Home, members of the rhythm band entertain themselves and audience.

ADJUSTMENT WAS DIFFICULT

Life wasn't too easy those first few weeks. This, according to Mrs. X's own confession. She remained aloof, shrank from participating in the community life, began, even, to develop certain symptoms that defied diagnosis.

Until the day arrived when Mother Bernadette, administrator of Mary Manning Walsh, came up with a brand new idea, a facility she possesses. Together with numerous other projects, why not inaugurate a hat shop, providing a convenience for those residents who would shop at will under their own roof, rather than embark upon tiring excursions along crowded city streets. Would Mrs. X volunteer her services in helping to organize and to operate such a shop? Her resistance vanished; she accepted.

Never was Mrs. X busier in her entire life than she is today, nor as interested, nor as enthusiastic about catering to her own especial clientele. The day of this interview, she apologized for the paucity of the stock, some her own original designs, some remakes from donations, and other models that in their original state were judged salable. The close-out sale of spring and summer numbers had just ended. "Soon

The neighbors in the community have grown used to seeing buses lined up in front of "420" into which the oldsters file happily to set off on an excursion.

Nothing like a "kaffee klatsch" to promote good fellowship. Here a group of residents gathers at the coffee counter to be served by smiling volunteers.

we'll be showing our fall collection of felts," she added enthusiastically. "Come back and see us then."

Gone are all of Mrs. X's symptoms. She doesn't have time, nor the need, for visits to the medical department. Years have dropped from her life. Again she is the busy, professional woman, preparing and exhibiting her line, comparing business with the newly organized dress and men's wear department next door, sitting in on meetings of the board of resident counselors of which she is a member.

The story of Mrs. X typifies the attitude of the Order of Carmelites, particularly that of Mother Bernadette of Mary Manning Walsh Home, toward geriatrics. Old people need to be occupied, to be diverted. Were Whistler to place on canvas today an interpretation of his mother, she wouldn't be pictured sitting idly with hands folded in a state of waiting. She would be actively engaged in ceramics or other arts and crafts, possibly trimming hats, or selling gowns for local consumption. That is, if her address were by chance 420 East 59th Street, New York.

"420" used to be the number of the old Orthopedic Hospital until in 1952 through the beneficence of Thomas Walsh, retired railroad executive, the Carmelites, with the blessings of His Eminence Cardinal Spellman, took over and converted it and two connecting buildings to community life for the aged. The Walshes, it seems, had left their estate to His Eminence to be used for whatever, in his opinion, was the greatest need of the archdiocese. Recognizing the ever pressing problem of our increasing aging population, His Eminence assigned to the Carmelites complete responsibility for this new unit of their chain of residences or clubs for old people.

ONLY THE NUMBER REMAINS

Now only the number "420" remains as a reminder of hospital days. Outdoor benches and tables flanking the front entrance are invitations to pause and to view the dramatic span of the Queensboro Bridge high above, or to bask in the sun with the morning or afternoon paper. No need to say "Goodbye" on the doorstep to normal life or liberty. Those entering as residents join a community group engaged in self-government, in occupational pursuits according to their individual tastes and aptitudes with liberal opportunities for diversion, for hobbies and social contact. They become guests of a hotel—a hotel offering special services.

Such services include complete hospital facilities supervised by a director of internal medicine and a director of physical medicine and rehabilitation. But these are provided in a separate building, with the express purpose of segregating, to the greatest degree possible, illness and incapacities from normal health and well-being. These heads are assisted by practitioners of general medicine, including a woman doctor, and by a staff of registered nurses and aides. Psychiatrists, psychologists and neurologists advise the Sisters in handling disturbed or maladjusted cases, and dentists, ophthalmologists and other specialists are available when needed. Authorities in geriatrics and rehabilitation likewise are on call for consultation, including among them Dr. Howard A. Rusk, director, Institute for Physical Medicine and Rehabilitation, Bellevue Hospital, who doubles in brass as a member of the Home's board and as its consultant in all phases of medical service. The presence of these affiliates does not, however, preclude the service of the private physician if so desired.

The tallest building of the group, eight stories, is devoted to modern living, with its chapel, lounges, libraries, card rooms, dining rooms, cafeteria,

shops, beauty parlor and assembly hall. Opening from certain of these rooms are patios equipped with tables and chairs.

"Unfortunate, perhaps, that our headquarters are not located in the country," Mother Bernadette remarks, a bit wistfully, "but we try to make up for it by enabling our guests to enjoy as much sun and air as the city affords."

As proof that dreams do come true, through the recent acquisition of a "country home" of six acres at Danbury, Conn., residents of Mary Manning Walsh are now privileged to divide their time between country and city living.

Once a month in a room furnished in true executive fashion, with directors' table and chairs, the resident counselors of Mary Manning Walsh meet to consider matters brought to their attention which would seem to merit study and discussion. There are nine in all—six women and three men—elected annually by the residents as their representatives. A Sister supervisor represents the administration. In addition, six other residents are invited to sit in on each meeting to determine their eligibility for regular appointment at some future date. Appointment to the counselor group is taken seriously. Certain elements of leadership are recognized as important and there is no lack of feeling and excitement within the community's walls as election time draws near.

Most of the items on each meeting's agenda center around suggestions placed by members of the household in the suggestion box. These are not complaints. Complaints, in fact, is a word definitely discouraged in this community. Ideas are deliberately solicited—constructive ideas that would seem to contribute something to the daily routine. The more important of these are passed along to an administrative council comprising a Sister supervisor, one of the counselors and the administrator.

REVIEWS MINUTES OF MEETINGS

The council reviews minutes of meetings of the resident counselors and announces its final decisions on the bulletin board in the main lobby so all will know what has happened. Sometimes important messages are presented in a form letter placed in the mail boxes. Also, to make sure that everyone is up to date on its affairs, the administrator presents the annual financial statement of the Home to the counselors.

Typical of sound administrative organization, special committees are assigned specific projects from time to time. These are extremely helpful in interpreting to administration the feelings of the resident group.

Mother Bernadette was talking not so long ago about meal hours. Present custom calls for the hearty meal of the day at noontime. "But I suspect," she explained, "that some of our family would prefer to have their dinner at night. We are making a study of it, anyhow," she added. "A committee of the residents is investigating and will present its conclusions."

"But will such a change not present administrative problems?"

"It is not a matter of what would be more convenient for us," Mother replied, "but what would seem to be best for our old people—what would permit them to lead lives as nearly normal as possible."

Mary Manning Walsh is a world unto itself, a world full of color, of activity, of interest, of diversion, providing for the practice of hobbies al-

Two of the best morale builders for a girl of any age are beauty treatment (left) and a new hat (center). The hat shop has been a howling success ever since it was opened. Below: Theatricals are another morale booster. Here a resident goes into a soft shoe dance while his fellow performers wait their turn to act.

ready acquired, as well as for others unanticipated. Mrs. X, for example, because of her experience as a milliner, followed her natural bent. But she, last of all, would have envisioned herself sitting at a directors' table making recommendations and passing resolutions. Every day reveals similar surprises and accomplishments unforeseen, totally unpredicted. "Never believed I could do it," is a frequent remark heard in the workshops and clubrooms.

They're doing something all over the place all the time at Mary Manning. During the winter the visitor may interrupt the rehearsal of a play. It is the dramatic group, working under the guidance of a professional. For the Home generally boasts some thespians among its guests. Big names in the entertainment world, noted for their generosity, frequently volunteer their services as directors and performers. A sizable assembly hall with stage, footlights and all essential equipment provides the setting.

Occasionally the sound of voices singing, good voices, too, add to the buzz of activity. This does not come from any radio or record player. It is the glee club warming up for a future performance.

A glance at the daily bulletin board tells the story. Under entertainment, the responsibility of one of the Sisters, are dancing groups, yes, square dances included, masquerades, musical appreciation groups, games, and movies. Every six weeks or so during the winter season, a variety show is billed with stars of the stage, screen or television participating. Happen by and likely as not you'll catch some old-timer going into his soft shoe dance to the enthusiastic applause of professionals and residents alike.

"Let's stay on pitch," the lady guitarist seems to be saying to her partner in this musical effort. Singing is an endless source of pleasure, to performers and listeners.

When they grow too old to dance, they are too old. But these residents have not reached that stage. A juke box and a well waxed floor are all the dancers need to be happy.

Summer brings no cessation in the diversional program. It continues, if in somewhat different form.

A warm evening finds the Mary Manning Walsh roof transformed into a garden spot with a bandstand in which the firemen's band volunteers a program of favorite selections. On such occasions the home audience is augmented by occupants of adjoining dwellings who, too, enjoy the free entertainment.

Neighbors in the community have grown accustomed to beholding buses lined up before number "420" into which the oldsters file happily, picnic-bent or to spend a few hours at the Mother House of the Order in Danbury, Conn. Two hours is about as much as these excursionists can take, but there are seldom any vacant places when the time of departure arrives. Particularly popular are the "extra" treats, such as a trip on the excursion boat that circles Manhattan Island, a courtesy extended by the operators of that line.

Whatever the season, there are ample opportunities for both diversion and occupation in arts and crafts. Hardly a day passes that some visitor does not pick up to admire the unique little ash receivers scattered about. They are home fabricated in the ceramics room by those who have adopted such work as their specialty. Others may choose to work with leather, to do carpentry, make jewelry, or specialize in needlework. What amateur photographer would not revel in the accommodations provided for his own especial needs. Practically every facility is there; if not, there is always the suggestion box.

Results of these home products are attractively displayed in showcases in a little shop adjoining an entrance to one of the buildings. The problem is to keep articles on the shelves, particularly during the holiday season. Stock moves rapidly because of the clever ideas conceived and the skill of their execution. Proceeds from sales here, as well as those derived from sales of articles in other community shops, are used to the benefit of the entire group, details of all such operations being the responsibility of certain Sisters.

Special projects are undertaken from time to time from which the participants may derive some direct financial benefit. During the last summer much enthusiasm was evidenced in forming

(*Continued on Page* 150)

The Case for Centralized Purchasing

Centralization of purchasing authority leads to more efficient and economical purchasing practices in addition to saving time of department heads

HAROLD E. SPRINGER

A PURCHASING agent has a public to consider whether he realizes it or not. The more conscious he is of the needs of this public, the better job he can do. In industry there is reciprocal responsibility among management, production, sales and the purchasing department. Sales may "wag the tail" but, at any rate, these basic groups must have the right material at the right time at the most economical cost in use. There is great pressure on the purchasing agent to coordinate these steps, which are important factors in the success of any business.

PRESSURES ARE SIMILAR

The pressures on the hospital purchasing agent are similar. A great variety of supplies is needed for the use of many categories of personnel. In some few cases, a patient's life may depend on immediate availability of certain supplies. If some materials for treatment are not at hand, the patient's stay may be increased. This makes hospital care more expensive for third-party agencies, the part-pay or free budget patient, or the private patient. Purchasing inefficiency costs someone money. In addition to the groups mentioned, the purchasing agent must consider his public relations with vendors.

The more centralized the authority of purchasing, the greater the interdepartmental responsibility. Centralized purchasing is here to stay, whether the authority is vested in the administrator, assistant, purchasing agent, or someone else performing a dual function.

Numerous reasons for a centralized system of purchasing have been given. One important reason is better control of products in reference to quantity, quality, standardization and issue. Centralized authority leads to specialized skill. This in turn leads to more efficient and economic purchasing practices. Being a member of the top management team permits the purchasing agent to have an insight into the over-all operation. Consequently, he can better judge each request for supplies and equipment. Another reason for centralized purchasing is the time saved the department heads. They can direct all their attention to the operation of their departments. Thus, it is evident that the arguments for centralized purchasing revolve around the saving of time and money.

In a centralized purchasing system the purchasing agent must realize that the purchasing function is one of service. The whole department must understand this philosophy. It is a service organization, not only to all departments needing supplies and equipment but to the hospital from an economy standpoint. If this basic philosophy is followed, the purchasing department will not become a dictatorial agency that rules with an iron hand. On the other hand, it is not likely to be overruled. It can maintain its objectives by a friendly, confident approach to each situation as it arises.

To be of the greatest service, an efficient organization is paramount. However, the advantages of central purchasing can be attained without extensive organization. The maintenance of a full-time purchasing agent and department may not always be practical when a hospital is under 100 beds. Even the small hospital should centralize purchasing in one person, usually the administrator.

The relationship of the administrator and the purchasing agent should be on a close staff level. The administrator must give definite support to the purchasing procedure established. The purchasing agent must be fully informed by the administrator on plans or procedures being developed. Most purchasing agents will be more than clerks if the administration considers them a real part of the team.

SHOULD FOLLOW PATTERN

Everyone recognizes that the administrator is the chief executive of the hospital. Consequently, if he wants to purchase, he has that prerogative. The extent to which he exercises this prerogative tells what he thinks of the purchasing department. For this reason, he ought to follow the pattern that has been established. His example will mean much to department heads. The administrator should work only through the purchasing agent in buying anything for the hospital.

I think the administrator should know from whom supplies are being purchased. At the same time, he has no right to insist that supplies be purchased from certain vendors unless they can furnish supplies in the needed quantity and quality, meet delivery dates and competitive prices and serv-

Mr. Springer is purchasing agent at Presbyterian-St. Luke's Hospital, Chicago.

ice. This sometimes is a touchy subject, but it is a cardinal rule.

There has been considerable discussion at various times as to whether the policy of the administrator in regard to purchasing should be written. The general policies as to the amount of inventory to be carried, the maximum amount of material, other than routine orders, that may be purchased without the approval of the administrator, and personal purchases should be understood. It is assumed that the person performing the procuring function and the administrator can communicate as matters of policy arise. The wise purchasing agent will know when to ask for help.

Although I feel that complete written policies are not essential, most authorities in the field advocate written policies.

The administrator, too, often takes purchasing for granted. One of the avenues that leads to better utilization of the purchasing department's potential service and more positive support is through regular reports to the administrator. In order to be useful, the reports should be clear and meaningful, but not long or they will not be read. Information as to the number of purchase orders, inventory position in terms of dollars, numbers, and month's coverage, market and price information, and report of savings should be included in reports. Actual figures as to the operation of the department, the number of requisitions handled, salesmen interviewed, and projects under way may be part of this report. Any recommendations should be included. Statistical graphs should be used where possible and reports should be brief and easy to read.

DON'T PLAY FAVORITES

Problems with department heads usually stem from arbitrary, obstinate or stupid actions by the purchasing agent. Preferential treatment for any department head will cause trouble. Department heads are often reluctant to give up their authority to purchase. It is the administrator's job properly to orient department heads on central purchasing. It is the purchasing department's responsibility to build up confidence and respect. Department heads will gain confidence if they know they are dealing with a capable purchasing agent who has an answer for their questions or who exercises enough good judgment to get information for them. There is nothing more frustrating to a department head than to call the purchasing department and get no satisfaction or help. At this point, he calls the administrator or a vendor friend and the old problem of decentralization shows itself. Centralized purchasing cannot succeed without complete cooperation and understanding by the administrator, purchasing agent, department heads, and the medical staff.

The purchasing agent will participate in the standardization committee meetings. In fact, he will have to show great leadership in establishing a simplification and standardization program.

One of the big problems is that some salesmen still insist on visiting departments without clearing through the purchasing office. This is done to be "of service," of course, but with a dollar sign in front of it. The time

COMPARATIVE STUDY OF HOSPITAL PURCHASING PRACTICES:

LOUIS BLOCK, Dr. P.H.

AN ANALYSIS of the approximately 100 questionnaires received from the hospitals included in the general hospital panel has yielded an interesting comparison of purchasing policies practiced by these hospitals.*

PERPETUAL INVENTORY

Of the reporting hospitals, a perpetual or running inventory is utilized in 83 per cent, with the other 17 per cent reporting that they did not use this method of inventory control. If hospital bed size is considered, 92 per cent of the large hospitals (over 250 beds) report that a perpetual inventory is used. A smaller number, 77 per cent of the smaller hospitals (those under 250 beds), have a perpetual inventory.

STOCK TURNOVER

An analysis of the length of time these hospitals maintained stocks of supplies of certain items was made. The median length of time these hospitals stored items in anticipation of expected demand is shown in Figure 1.

FIG. 1—STOCK TURNOVER RATE

Item	Median Time In Weeks
Surgeons' gloves	8
Dressings	8
Sutures	9
Hypodermic needles and syringes	12
Rubber catheters	8

The maximum time an item was stocked was found in connection with surgeons' gloves, needles and syringes. Some hospitals bought enough of these items to last a year, based on normal demand, without replenishment. Rubber catheters, on the other hand, were stocked to a lesser degree, with some hospitals reporting that they only had on hand a week's supply.

The size of the hospital apparently was not a factor in the rate of stock turnover.

METHOD OF ORDERING SUPPLIES

About two out of three hospitals order supplies as their stocks are depleted. A predetermined regular interval of time is the basis for ordering in 22 per cent of the hospitals. The remaining hospitals (11 per cent) use a combination of these two methods, placing orders at regular intervals for

*Based on information supplied by Taylor, Harkins and Lea, Research in Medical Marketing, Philadelphia.

Dr. Block is chief, Research Grants Branch, Division of Hospital and Medical Facilities, Public Health Service, Washington, D.C.

has come for the salesman to stop romping through the building visiting departments. He will find it wise to stop first at the purchasing office. Yet I hear some salesmen saying, "But I'll never get any farther." This is a question for the purchasing agent to decide. First of all, the purchasing agent must not be arbitrary and say "absolutely no." However, he must not permit salesmen to go to departments promiscuously. The salesman must understand the general policy. He then must have something worth while to talk about. Often a telephone call made by the purchasing agent to the department will disclose whether the department head wants or needs to see the salesman. An absolute "no" will mean that some salesmen may go behind his back and contact the department anyhow. They are reluctant to do this for, if the department does want the item, the purchasing agent may get it from someone else anyway. No control over the salesman is as bad as too much control.

A positive approach to this problem is best. Relations of confidence and cordiality are important. Salesmen often have valuable information and may give valuable service to the purchasing agent and the department head. There are still some salesmen who come with nothing but the old high-pressure "pitch." Their day is fading. One of the ways to keep salesmen from contacting department heads is to give them adequate opportunity to see the purchasing agent. One morning a week or month is not adequate time. Definite hours during the week to see all salesmen help both.

PERSONNEL BETTER INFORMED

Hospital personnel is being informed about new products and developments through magazine advertising, catalogs in the *Hospital Purchasing File*, and technical literature. Hospital organizations are fostering institutes and conventions which are attended by many people on management level. This makes it less necessary for salesmen to see department heads. Occasionally, a department head will ask to see a salesman. If the purchasing department cannot furnish the information, especially if it is of a technical nature, the company should be called and an appointment made for the salesman and the department head.

There are occasions when a department will call indicating that certain supplies are inferior or suggesting that another product be substituted for the present one. Theoretically, complaints of inferior material should not arise, supposing, of course, that careful thought and cooperative planning precede all purchase orders. However, all complaints must be given careful and friendly consideration. This helps to create a good working relationship. After investigation, perhaps both parties will be instrumental in saving the institution money.

In summary, good relationships with the administrator and department heads result when the purchasing department operates on the philosophy that it is a service organization, when problems are approached with mutual confidence, and when all members of the hospital team understand the reasons for and the value of a competent, centralized purchasing department.

PERPETUAL INVENTORIES, STOCK TURNOVER, METHODS OF ORDERING

certain supplies, and buying other items as the need arises.

A surprising number, 93 per cent of the hospitals, order items by specific brand name. Only 2 per cent did not specify brand, while the remaining 5 per cent specified a particular brand on some items only.

SUPPLY HOUSES

In order to protect themselves against possible shortages, the general practice in most hospitals is to order from more than one supplier. Sixty-six per cent of the hospitals reported that policy as compared with 34 per cent who order from one supplier. There is practically no variation in these percentages between small and large hospitals.

In Figure 2 are listed percentage figures showing the frequency in which the following factors were indicated as determinants of the quantity of an item ordered.

FIG. 2—FACTORS DETERMINING QUANTITIES ORDERED

	Large Hospitals (250 Beds and Over) Per Cent	*Small Hospitals (Under 250 Beds) Per Cent*	*All Hospitals Per Cent*
Storage facilities	86.5	75.5	80.2
Quantity discounts	62.2	75.5	70.0
Possible price changes	64.9	61.2	62.8
Deterioration	64.9	51.0	57.0
Rate of usage	10.8	14.3	12.8
Credit limits	5.4	6.1	5.8
Transportation or delivery	2.7	4.1	3.5
Others	5.4	2.0	3.5

Of the reporting hospitals, only 9.3 per cent had purchasing committees. Because so few of the hospitals reported that they have such committees, no really substantial data could be obtained as to their organization. In all cases but one, where the committee was concerned with current supplies, the purchasing agent was a committee member.

The administrator served as a member of the committee in all cases where the committee was concerned with capital expenditures. Most of these committees had regularly scheduled meetings and more than half of them dealt with both capital expenditures and current supplies.

ABOUT PEOPLE

Administrators

Frederic C. LeRocker, director of support activities of Memorial Center for Cancer and Allied Diseases and the Sloan Kettering Institute for Cancer Research, New York City, will assume the position of director of the Sloan Institute of Hospital Administration in the Cornell University graduate school of business and public administration shortly after the first of the year. Mr. LeRocker will also be professor of hospital administration. A graduate in 1951 of the University of Minnesota course in hospital administration, Mr. LeRocker went to Memorial Center as associate general manager in September 1953. He had previously been assistant administrator of San Jose Hospital, San Jose, Calif. He is a member of the American College of Hospital Administrators and of the American Public Health Association and also serves as consultant on hospital administration to the professional examination service of the A.P.H.A. Before he entered the hospital field Mr. LeRocker had been with the Socony Mobil Oil Company in the Middle East and Balkans. During the war he was assistant to the president of the U.S.O.

Robert S. Bazzell, administrator of Memorial Hospital, Perry, Okla., has been named administrator of Oklahoma Baptist Hospital, Muskogee. He succeeds **J. F. Murrell** who resigned to move to Hugo, Okla., where he will work with the Golden Age Home Project of the Oklahoma Baptist Convention.

Jacques Cousin, director of Oakwood Hospital, Dearborn, Mich, since 1952, has been appointed executive director of the newly reorganized Greater Detroit Area Hospital Council. **Stuart Walker,** executive secretary of the former Detroit Area Hospital Council, will become Mr. Cousin's assistant in the new council. **Neil McGinniss,** assistant director of Oakwood Hospital, will succeed Mr. Cousin. Mr. McGinniss served as purchasing agent and administrative assistant at Bethesda Hospital, Cincinnati, for five years, and holds a master's degree in hospital administration from Columbia University. He has been assistant director at Oakwood Hospital since July 1956.


Jacques Cousin


Neil McGinniss

Dr. Basil C. MacLean has resigned as New York commissioner of hospitals, to accept an appointment as president of the national Blue Cross Association. A founder of the organization, Dr. MacLean was chairman of the original Blue Cross Commission. From 1935 to 1954, he was director of Strong Memorial Hospital, Rochester, N.Y., and professor of hospital administration at the University of Rochester. Dr. MacLean started his hospital administrative career as medical superintendent of Montreal General Hospital, a post he held from 1927 to 1930. From 1930 to 1935 he was superintendent of Touro Infirmary, New Orleans. A past president of the American Hospital Association, Dr. MacLean is a charter fellow of the American College of Hospital Administrators and was president from 1936 to 1937. He is a member of the editorial board of The MODERN HOSPITAL.


Dr. B. C. MacLean

The Blue Cross Association will establish its headquarters office in New York City to conduct a national sales program for Blue Cross, Robert T. Evans, chairman of the Blue Cross Commission, said. "For a long time Blue Cross plans throughout the nation have felt that greater attention needed to be placed on the nationwide employer," he added. The Blue Cross Association under Dr. MacLean's leadership should provide an ideal answer to this need."

The Blue Cross Commission will continue as part of the American Hospital Association to serve as the national coordinating agency for Blue Cross plans in the United States and Canada, Mr. Evans explained. "The commission will retain activities which are concerned with management problems of plans, while the association will deal primarily with sales and member-directed functions," he said.

Charles H. Singer has been appointed administrator of the hospital division of the Brooklyn Hebrew Home and Hospital for the Aged, Brooklyn, N.Y. Mr. Singer has been assistant administrator at the hospital for the last four years and before that was associated with Beth Israel Hospital, New York. He is a candidate for membership in the American College of Hospital Administrators.


Charles H. Singer

Edward G. Hertfelder has been named administrative assistant and director of outpatient and emergency clinics at University Hospital and Hillman Clinics, University of Alabama Medical Center, Birmingham. Mr. Hertfelder formerly was night administrator at the hospital. He succeeds **Henry A. Swicegood,** who recently resigned to accept a hospital position in El Paso, Tex.

Sister M. Fabian is the new administrator at St. Thomas Hospital, Akron, Ohio. A graduate of the hospital administration program at St. Louis University, Sister Fabian completed her administrative residency at St. Vincent's Hospital, New York.

Anthony C. Garrick is the new administrator at Arizona State Tuberculosis Sanatorium, Tempe, Ariz., succeeding **Henry F. Lesem** who retired. Mr. Garrick formerly was director of the crippled children's division and administrator of the Crippled Children's Hospital under the Arizona state welfare department.

Sister Marie De Liesse has been named administrator of Misericordia Hospital, Milwaukee, replacing **Sister Holy Heart of Mary** who has taken up new duties at the mother house of the Sisters of Misericorde in Canada. Sister De Liesse has served as director of nursing services in Pana, Ill., and Green Bay, Wis., and as superintendent of the order's general hospital, Winnipeg, Manit.

Robert R. Martin, assistant hospital administrator with the North Carolina Medical Care Commission, Raleigh, has been appointed assistant director of Rex Hospital, Raleigh, where he completed his hospital administrative training in 1954.

(*Continued on Page* 178)

THE MODERN HOSPITAL OF THE MONTH

The playroom shown on this month's cover is located on fourth floor of the new Fairview Park Hospital of Cleveland, opened in May 1955.

Relocation Gave Them Room to Grow

It also affords Fairview Park Hospital an opportunity to serve a growing community that needs a hospital

VERNON D. SEIFERT

OUTLINE OF CONSTRUCTION COSTS

Total project cost, including Groups 1 and 2 equipment		$4,700,000.00
No. of beds	188*	
Cost per bed		$ 23,500.00
Total square feet	185,860	
Square feet per bed	929.3	
Cost per square foot		$ 21.39
Total cubic content	2,182,230	
Cubic feet per bed	10,911.15	
Cost per cubic foot		$ 1.82

*Planned for 212 additional beds

The main lobby of the new hospital looks out on a pleasant suburban street. From their windows patients see the lovely wooded Rocky River Valley.

ON MAY 1, 1955, the new Fairview Park Hospital in Cleveland opened its doors to the public. This event culminated nearly 20 years of planning, fund raising, community study—to mention only a few of the many activities that go into the development of a program such as ours.

In the late 1930's and early 1940's, it became increasingly evident that the future field of service open to our hospital was not in the west central Cleveland area then served by Fairview Park Hospital. More and more, strong community development was in the direction of the suburbs, the outlying areas. This followed a pattern consistent with that of most major cities of our nation.

The suburban trend was characterized by rapid unprecedented growth on the far west side of Cleveland. New homes, new market centers, whole new communities were developed in what had previously been rural, summer home, and agricultural districts. As

Mr. Seifert is administrator, Fairview Park Hospital, Cleveland.

The hospital was designed by Garfield, Harris, Robinson and Schafer of Cleveland.

In the corridor that leads from the main lobby and the administrative areas back to the auditorium the gift shop is strategically located to lure the passers-by and the windows are decorated so as to catch their eyes.

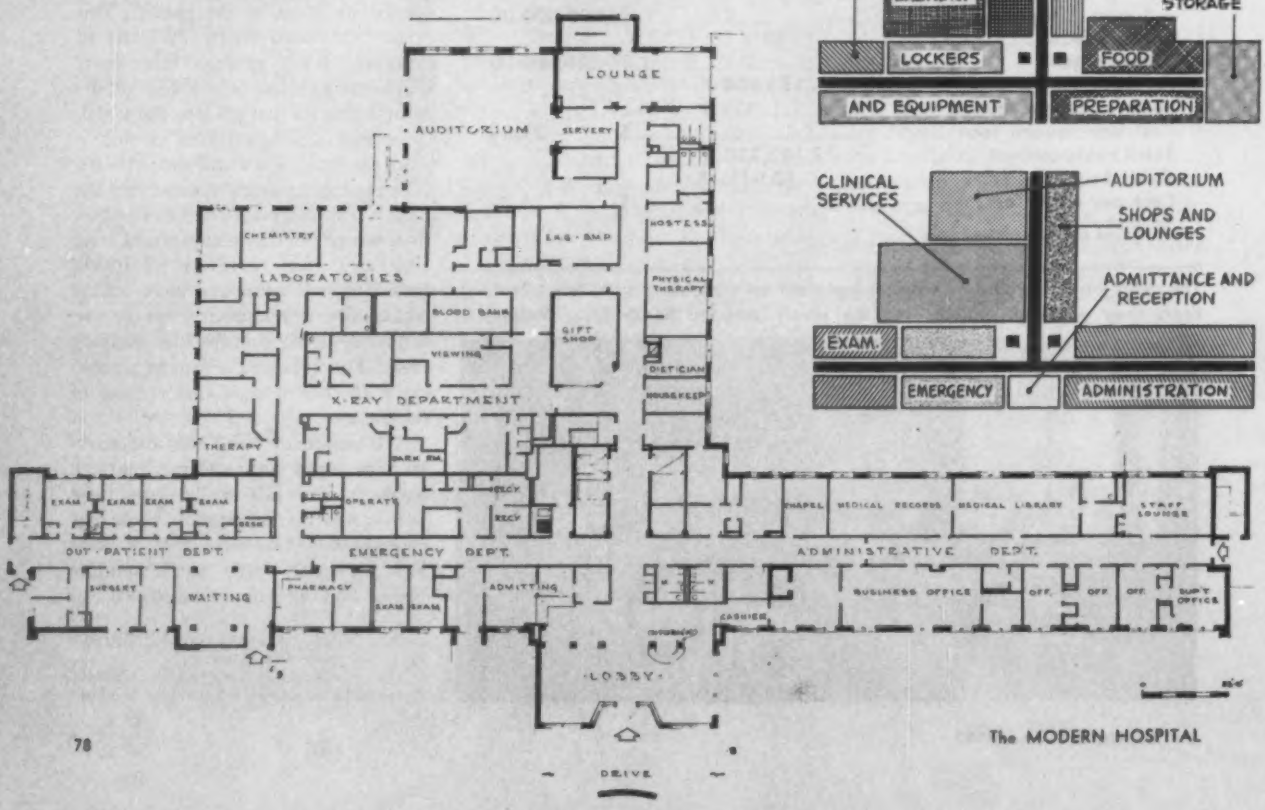
these new communities developed, the lack of adequate general hospital facilities became more and more a pressing problem. The supporting hospitals available were all located within a radius of 2 miles of the center of Greater Cleveland. It was obvious that bed distribution seriously needed re-evaluation in order to meet the needs of this new community.

Our board of trustees, faced with the necessity either to expand at the present location or to relocate elsewhere, was impressed by this new development of more than 125,000 people, springing up in areas too far removed from existing hospital facilities. This was the picture during the early stages of planning on the part of our board. Relocation to serve this growing population appeared to be the course best suited to the future of our hospital.

At about this same time, efforts were started in the direction of a broad study of the bed distribution throughout Greater Metropolitan Cleveland. From this developed the

FIRST FLOOR

The hospital's special service departments are all grouped together on the first floor for greater accessibility.



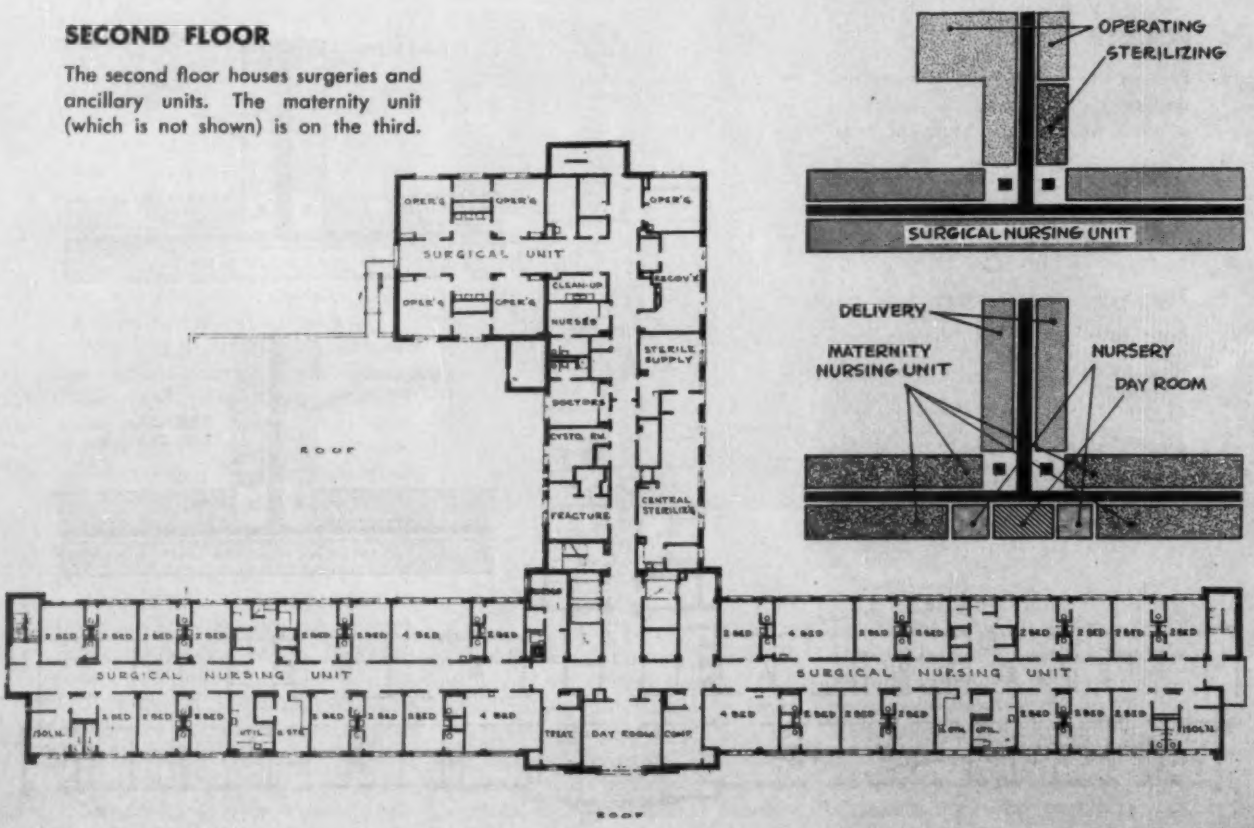
Greater Cleveland Hospital Fund, a community-wide program destined to provide the funds necessary to revamp existing institutions and to assist in the construction of new facilities to effect a more workable bed distribution plan for the great metropolitan area of Cleveland. A campaign to produce possibly $9 million for capital expansion was launched. This campaign was built around two basic objectives: first, that of redistribution of beds to meet the needs of growing suburban areas; second, to enlarge and modernize existing facilities to serve the established "core areas" of the city. This program complemented Fairview's plan, thereby giving our hospital much needed additional support in order to accomplish our objective satisfactorily.

The detailed planning for the new hospital got under way early in 1951, and continued up to the beginning of 1953, when bids were opened and the contract awarded for the new building. Construction was started in March of 1953, and the building was completed in April 1955. At the time of dedica-

Ministers and their congregations in the churches of Greater Cleveland raised the funds for furnishing this prayer chapel located on the first floor of the hospital, which is available to patients of all three major faiths.

SECOND FLOOR

The second floor houses surgeries and ancillary units. The maternity unit (which is not shown) is on the third.



The snack bar, complete with soda fountain and stainless metal sink and serving unit, is located near the gift shop and operated by women volunteers. Both of these are patronized by patients and hospital employes.

tion, the total investment in the facility, including land, equipment and furnishings was $4,730,000. These funds came from the following sources: the Greater Cleveland Hospital Fund, Public Law 725, the state of Ohio under the Hill-Burton program, public subscriptions, and the hospital's own resources.

Architects for the project were Garfield, Harris, Robinson and Schafer of Cleveland.

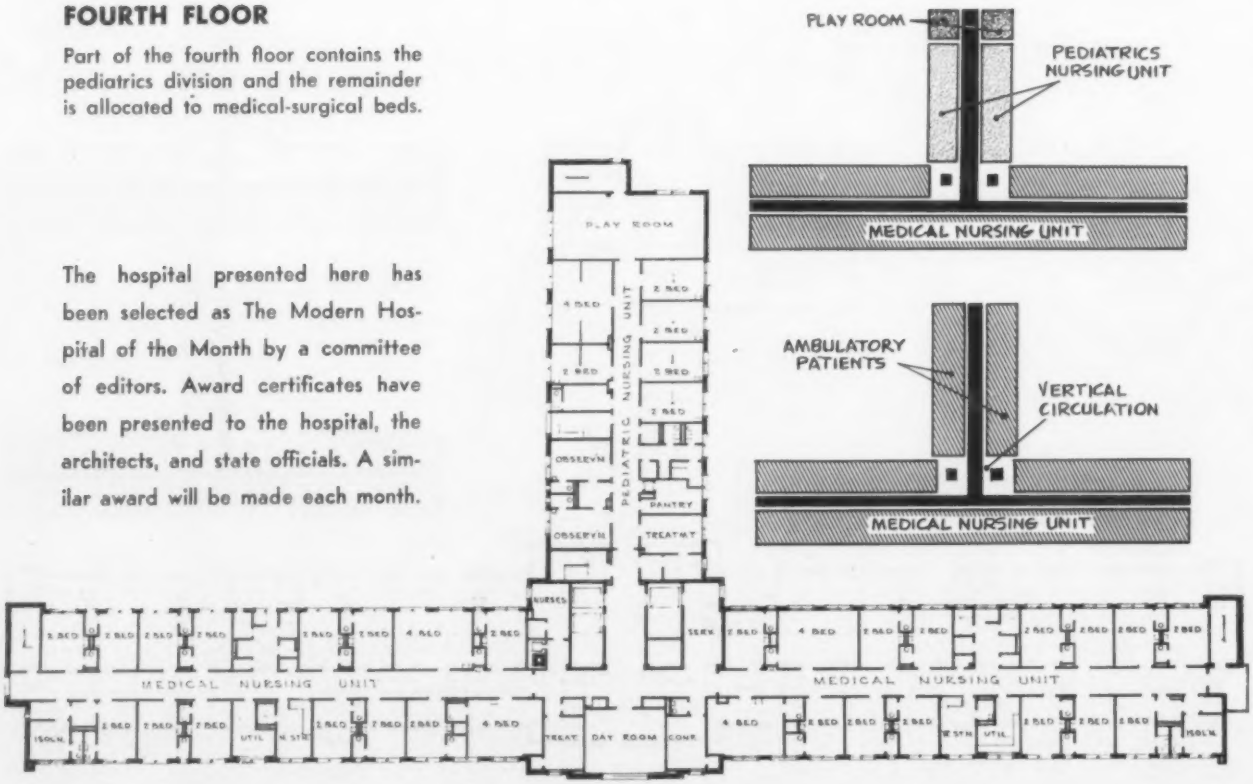
Some of the more interesting design characteristics of the building are:

1. All departments planned for ultimate growth to 400 beds.
2. Sufficient strength in structure to allow future vertical expansion by adding sixth and seventh floors.
3. Proper orientation of building on 13 acre site, so that horizontal growth can be effected with minimum difficulty.
4. Building site picked for proximity to public transportation; well traveled main traffic arteries in all four directions.
5. Pleasant scenic view.

FOURTH FLOOR

Part of the fourth floor contains the pediatrics division and the remainder is allocated to medical-surgical beds.

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects, and state officials. A similar award will be made each month.



6. Adjacent to major market centers.

7. Site well situated in a geographic center predominantly residential; many large major industries within a 3 mile radius.

Some other design characteristics of interest are (1) the use of extruded aluminum wall sections, (2) aluminum windows throughout, (3) unique single-tube electronic switch pneumatic tube system, (4) pillow-speaker radios, (5) oxygen at each bedside, as well as telephone, and (6) intercommunicating nurse-call system.

Much thought was given to the comfort and convenience of the patients. In the patients' rooms, for example, soft pastel colors were employed because of the psychological lift they give to sick patients. The rooms themselves are spacious—the cubic footage compares favorably with that of every hospital in the area, including the old Fairview Park Hospital. The large windows which enable patients to look out on the beautiful Rocky River Valley are expected to be good for their morale also.

The pediatrics department has spacious playrooms (see this month's cover picture) overlooking the valley. The playrooms are equipped with toy chests, a library, small tables, and colorful murals done by hand. The ward has 16 glass-partitioned roomettes, plus isolation units and treatment rooms.

On the first floor is the $10,000 Prayer Chapel which is available for all three major faiths. Funds for furnishing and decorating the chapel were raised by the ministers in the area and their congregations. Local ministers will provide chaplaincy service to all patients who request it.

Also located on the first floor are the medical library combined with the nursing library, medical staff lounge, women's lounge, where many volunteer groups will do in-hospital work, and the Philip Vollmer Jr. Auditorium which has a seating capacity of 250 to 300 persons. This auditorium was named in honor of the hospital's superintendent emeritus.

We feel the overwhelming demand upon the hospital since our opening date has more than justified the enterprise despite our uncertainty in the early stages of planning. We have experienced an occupancy rate of more than 92 per cent since the building has been opened.

The fifth floor of the structure, now used by the school of nursing, was designed as three additional nursing units. A school of nursing building is currently under construction and will be located adjacent to the main hospital building, connecting at its southwest corner. The three additional nursing units will provide 90 additional adult beds and 20 bassinets; they are scheduled for operation about February 1. The present estimates are that 292 beds and 68 bassinets which will then be available will be adequate to meet our current needs. The planning committee, however, is already looking forward to the next step in our development, to be completed in five to 10 years.

Looking to the future, we anticipate continued need for growth in all directions.

Above: A typical two-bed room. Soft pastel tints on the walls are designed to keep patients' morale high, as are the cheerful draperies which were made in the sewing room of the hospital. Rooms are equipped with adjustable height beds, central oxygen distribution system, and radio and television connections. Below: The administrator's office features wood paneling.

These Supervisors Have Learned How to Think

The supervisory training program at this hospital not only has taught supervisors to think creatively, but has produced such concrete results as training manuals and improved technics devised by the staff

E. J. O'MEARA

AUTHORITARIAN or democratic? Exclusion or participation? Do it yourself or do it through others? You control or they control? Dominate or motivate? Black or white? . . . or gray?

These and many others are questions that run through the minds of supervisory personnel at the Altoona Hospital, Altoona, Pa., in the pursuance of their duties. They are questions that have been raised through our latest program of patient care improvement—supervisory training.

We feel that the outstanding accomplishment of our training program is that our supervisors now think in conceptual terms. They don't think in terms of standard answers and formulas that we have parroted to them, but rather within a framework of their own conceptions of leadership, determined by their own standards and their own experiences.

We have enjoyed other, more concrete results:

Following our training program, our medical records librarian developed an excellent procedure manual for her department. This manual gives a complete breakdown of the responsibilities of each job, informing each worker what to do, how often to do it, and how well it must be done. It also contains rules and regulations regarding the release of information from the medical chart. Our librarian developed this manual because she felt that it would better orient the new employe, let her know exactly what is expected of her, and tell her how to do the job. The librarian felt that each employe should have a reference available during her employment so that she might continually check on the standards required.

Because our housekeeper was impressed with the need for establishing performance requirements, she developed quantitative standards for the various units of the hospital. That is, she determined how many minutes it should take to wet-mop a bathroom, toilet, kitchen or utility room, and how long it should take to damp-mop a private, semiprivate or ward accommodation. She felt that this was desirable because she realized that a yardstick of acceptable performance, mutually understood by *both* the worker and the supervisor, was as good for the employes' morale and satisfaction as it was for the supervisors.

MADE FLOW PROCESS CHART

Methods improvement studies also were initiated as a result of our program. Our housekeeper, for example, through the use of a flow process chart, studied the method by which her men were cleaning corridors and rooms. The study disclosed an undue delay in elevator transportation. A revision of the assignment system reduced this nonproductive time to a point where the same work is being done with one less employe.

Many other examples demonstrated the effectiveness of our program. Several participants requested that they receive more adequate cost reports so that they might more effectively tackle the problem of costs. The participants as a group requested that the hospital initiate a suggestion system to increase employe participation. The group volunteered to act as a committee to develop and administer the program.

More important still, I definitely have the feeling that the supervisors enjoy a new attitude which makes them part of the management team. It is easy to see in their daily considerations and decisions that they no longer feel like adversaries of top management, defending their particular realms, but like one unit, an integral part of management, responsible for the effective administration of their particular assignments.

What *is* supervisory training? It can mean whatever we wish it to mean. Basically, it means training that will increase the quality of supervision. In hospitals, it means increasing the quality of supervision toward the goal of providing the best possible care at the lowest possible cost.

It is necessary to consider the nature of hospitals and hospital personnel when discussing supervisory training. We in hospitals have worked ourselves into an unenviable position regarding supervision. Hospitals are, and will continue to be, the purveyors of personal services. Our product will always be the actions of people. However, through our functional departmentalization, accreditation standards, state licensure standards, and many other well meant requirements, we have insisted that technical specialists be the supervisors of the people who administer the care.

For example, I cite the dietary, pharmacy, nursing and physical therapy

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This is the first of two articles by Mr. O'Meara on supervisory training. The second will appear in the February issue.

departments. Consequently, instead of placing supervisors on their jobs because of proven ability and experience in the crucial boss-worker relationship, as industry does, we are necessarily requiring technical specialists with certain academic degrees to perform this function of supervision. Our problem is further complicated by the shortage of these specialists to the point that most hospitals do not enjoy a selection of supervisors, but instead, appoint supervisors solely on the basis of academic achievement.

Where does this leave us? It leaves us with a tremendous responsibility to develop within our supervisory personnel those traits that make for more effective supervision of people. We must "add to" the formal training and experience of our people so they will be equipped with every possible resource. They must successfully tackle this complex function of attaining the hospital's objectives through other people.

It follows that we in hospitals must change our basic approach to supervisory training from that held by some industries. That is, we are in no position to consider the "trait approach" whereby we seek basic traits of the successful supervisor and screen aspirants on the presence or absence of these traits. Ours is not a screening or selective job, but one that will *develop* traits and skills, and add to the existing ability of our supervisors.

What should be the objectives of a supervisory training program in hospitals? Of course, the over-all objective would be to provide the best possible care at the lowest possible cost. Beyond that, the objectives should be refined to meet local situations. The objectives could include better supervision to result in improved morale, better public relations, higher quality of work, lower costs, better organization, better planning and coordination.

Several indicators are available to show the administrator areas of greatest need. A patient opinion questionnaire can tell a great deal about whether public relations generally are good or bad. Turnover and absenteeism reports can pinpoint morale problems. Employe suggestion systems often point to areas of need. Exit interviews with employes bring out hidden problems. Employe attitude surveys, visitors' complaints, department head conferences, medical staff complaints, and budgetary reports all serve to diagnose the basic ills of an organization.

Having determined the areas of need, we should next give some thought to course content. Most authorities will agree that course content, and even course objectives, should be determined by the participants themselves. This makes sense—for who knows their weaknesses better than the supervisors themselves?

Should the course be based on conceptual core ideas around which discussion may be based, or should it deal in "how to do it"? Again, the makeup and background of the participants will be the determining factor. Should the course explain hospital policies and hospital costs, or possibly orient each supervisor to all the other departments in the hospital? It depends on what supervisors need.

In establishing our program, individual and group discussions were held with the supervisors to obtain their ideas on course content. It is the practice in some industrial concerns to pass out check lists which might contain several subjects. Supervisors are given the opportunity to check the order of their preferences, and those subjects which receive the greatest number of votes should be selected.

Our supervisors chose a combination of core ideas and "how to do its." Some subjects included in our course were organization study, work distribution analysis, methods improvement, work simplification, planning, coordinating and controlling work, instructing new workers, disciplining, problem solving, and supervisory responsibilities.

In determining who should participate in the program, we decided that it should be on a voluntary basis. However, we felt that, starting at the top, succeeding levels of management should have the opportunity to participate in the program before their subordinates participated. An attempt was made to keep from mixing levels of supervision in the program, as the type of interest may vary with different levels. Consequently, our first group consisted of department heads. Following the assistant department heads and various supervisory personnel, it is our plan to include all head nurses and assistant head nurses.

In a succeeding article, we will consider the problems of who should teach the program, how it should be taught, and what resources and planned programs are available.

SELF-AUDIT FOR SUPERVISORS

Do I really know my job and do I apply my knowledge in my daily routine?

Do I live the ethics and ideals of my profession?

Do I feel and show interest in my employes and patients?

Do I give clear and complete instructions?

Am I fair and just to everyone under me?

Do I understand and faithfully pass along the company's policies?

Do I give prompt and clear answers and decisions?

Am I enthusiastic about my job, my department, my company?

Do I keep my temper?

Do I throw my weight around?

Do I motivate people properly? Do I make them do things or do I make them *want* to do things?

Do I do an honest day's work?

Do I face the tough jobs personally and face them first?

Do I share the credit for jobs well done and the blame for jobs badly done? Do I say "I" or "We" when it's a question of credit?

Do I plan my work and do I teach others how to plan theirs?

Do I have confidence both in myself and in my subordinates?

Do I delegate responsibility and authority?

Do I criticize destructively or creatively? Openly or privately? Do I mix praise with blame?

Do I keep company and personal secrets? Or do I pass along gossip and rumors?

Do I make others feel important and necessary?

Do I listen to complaints and suggestions, act on them if they have merit, or tactfully point out why they do not have merit?

Is my private life a wholesome influence on my career?

Am I courteous? Are my manners good?

Do I watch my personal appearance and grooming?

Do I use good judgment and maintain my poise, especially in periods of emergency or crisis?—FRANK P. FOGARTY, *trustee, Children's Memorial Hospital, Omaha, Neb.*

Push the Button and There's the Record

A great help to harassed clerks is the new office machine which is said to reduce the time required to copy insurance records by as much as 75 per cent

FRANK HILL

THE 100 bed Potsdam Hospital, Potsdam, N.Y., is like most other small hospitals, in that we are always looking for ways to simplify or reduce our administrative tasks. One of our major chores is that of accurately copying an endless procession of bills, medical and administrative records for insurance transcripts, magazine articles and doctors' notes. We have taken a big step in the right direction by bringing a new office machine into our administrative family.

The machine is a new and extremely simple-to-use photocopying device. It does all sorts of odd copying jobs quickly and legibly. But probably its outstanding contribution to our administrative problems is the time saving that it has made possible on the reproduction of records for insurance transcripts. We have estimated that this simple expedient of photocopying has reduced the time needed to turn out insurance transcripts by an average of 75 per cent. A like time saving has been realized on other copying jobs, too, such as duplication of hospital bills and discharge records.

The operation of the machine is not complicated; the average stenographer or office assistant can easily learn its use in a few minutes. Roughly, the steps in its operation are as follows: (1) The document to be copied is placed in the printer, together with a sheet of matrix paper; (2) the printer is closed and an exposure is made, usually about 15 seconds; (3) the matrix is removed from the printer and floated into the activator solution contained in the base of the machine; (4) the matrix paper and the paper on which the print is to be made are pulled out of the activator together between two rollers, which squeegee them dry and at the same time press the print paper hard against the matrix to transfer the print image; (5) the paper is stripped from the matrix immediately and is dry and ready for use—a positive copy duplicate of the original. At least three such copies can be made from one matrix sheet in about 60 seconds (we have often made four good copies and occasionally even five and six from one matrix). There is no waiting for copies to dry and the room need not be darkened.

The administrator makes use of the photocopying machine which occupies little more space than a standard typewriter and can produce three exact copies of any form in a minute.

In admitting patients and keeping medical and administrative records on them, there are about 26 forms which may be used. At one time or another practically all of these forms must be reproduced, usually for insurance transcripts. In most cases, this is used to necessitate retyping of records by hand, an obviously time-consuming routine.

About a year ago we decided to purchase the machine which we are now using. We have been able to turn out clear, thoroughly presentable photocopies of all our forms. The material copied comes in a variety of colors—

Mr. Hill is administrator of the Potsdam Hospital, Potsdam, N.Y.

black and brown printing, typing, red and blue ink—but the quality of the photocopies is still uniformly good.

Photocopying has numerous virtues, not the least of which is its unquestionable accuracy of duplication. Doctors, like the rest of us, often scrawl madly in a hard-to-read hand when making notes. Photocopying makes it unnecessary for our girls to spend time deciphering medical hieroglyphics. It eliminates as well the possibility of transcript errors.

There are many other plus factors. Our girls do double duty, working in the admitting office *and* the record room. With the photocopy machine one person, full time, and a second, part time, can handle records *and* admitting. It averages out to about one and one-half person needed to transcribe doctors' dictation, type records, handle admitting, and make photocopies of bills and records. This, of course, is with the help of the front office people who take care of admitting during off-hours.

The commonest photocopying job is the insurance transcript of medical admissions and discharge records. A checkup for insurance purposes usually calls for a photocopy of our combination summary sheet, personal history and physical examination form, laboratory reports, and x-ray report. For patients who have spent some time in the hospital, copies of the forms already mentioned, plus the progress record, report of anesthesia, operative record, graphic charts, occasional drawings, the continuous order sheet, and nurses' records (any number of these may be included) may be required. And the actual time saving resulting from photocopying increases in proportion to the size of a patient's file, of course.

We average one insurance transcript daily and have had as many as nine per day. Before instituting photocopying, an overload of transcripts or other work meant delay in getting the records out. Now we are able to complete transcripts promptly without overtaxing our office employes. And, as I mentioned earlier, we have cut the time required to make insurance transcripts by about 75 per cent.

Our photocopying machine has helped with a good many other duplication problems. For example, when income tax time rolls around and the annual deluge of requests for copies of hospital bills begins, we can take care of these requests quickly and with a fraction of the effort formerly required. We must duplicate records not only for insurance companies but also for the county welfare department, Veterans Administration, and state compensation bureau. Photocopies are always correct and can be turned out by anyone in the office.

When there are errors in bills and invoices from our suppliers, it is a simple matter for me to jot longhand notations on the original bill, then step over to the machine and make a quick photocopy of the incorrect bill, and put it in the mail. This reduces both correspondence and the typing load and still gets fast action from suppliers.

Often I find it worth while to make copies of articles from medical and hospital publications for members of the hospital staff and board of trustees. Photocopying eliminates time consuming typing of such material. For example, before the inspection of our hospital by the Joint Committee on Accreditation of Hospitals, we made photocopies of 11 pages of printed information about this subject. Twelve copies were distributed among staff people, who would have a part in the inspection proceedings, to inform them beforehand on what to expect. It took only two matrix sheets to produce the 12 copies, six copies per matrix, and all were perfectly legible and clean looking.

There is one more important factor that deserves attention. When we first bought our photocopy machine we had our doubts about the acceptability of photocopied records for lawyers' use and court evidence. To date, both our local courts and law firms and those outside our area have found our photocopied records acceptable as evidence and have raised no objections to their use.

Combination summary sheet, personal history and physical examination form, which, with other reports, make up the insurance transcript.

HOSPITAL HISTORY SHEET

COPY OF RECORD FROM POTSDAM HOSPITAL , 50 Leroy St. Potsdam , N.Y.

Furnished to _____ Date 12/23/54

ON: _____ Claim No. XXXXXX

Name John Doe Address Leroy Street Town Potsdam State New York

Date Admitted 11/1/54 Date Discharged 11/17/54

Case No. BB 1000 Date 12/28/54 Doctor XXXX

FINAL DIAGNOSIS:
Rheumatic fever.

Age 8 Sex M Race W

Height _____ Weight _____

Family history age health if living
Father
Mother
Brothers
Sisters

Past History : Diseases from childhood to date habits, social data.

Chief complaint: Date and mode of onset, probable cause, course.

"Pain and swelling left knee and right wrist."

Normal exanthemata. Had a cold about a month ago and has been feeling badly ever since then. Yesterday complained of pain in left knee and right wrist.

XRAYS: Chest 11/15/54

Radiographic studies of the chest reveal no abnormality of the heart shadow as to size, shape or position. The trachea is in the midline. The thoracic cage is not remarkable. The hilar shadows are not unusual. There are no changes in the lung field to suggest disease of of clinical importance.

Diagnosis: No evidence of recent pleural or pulmonary disease of clinical significance.

Operative record: findings and what was done

SEE ATTACHED LABORATORY FINDINGS

This case history was signed by _____

Information transcribed by _____
Librarian Potsdam Hospital

New Trends in Training Volunteers

The operative word is "training" so that volunteers work with an understanding of the hospital's needs

VIOLA R. PINANSKI

THE need for volunteers in the hospital is now accepted almost universally. The hospital director and the trustees who deplored these unwanted, meddling busybodies who wanted to take over the operation of the hospital and who seemed to know less and less about more and more, have practically vanished in the same way we hope, as have the women who were responsible for this feeling. (One of my favorite true stories is of the auxiliary president at a New England Hospital Assembly who said that one of the functions of her auxiliary was giving teas for departing administrators.)

MORE CLEARLY DEFINED

One can hardly blame an administrator who does not want volunteers who do not know where they are going, what they are doing, and do not understand their relationship to hospital, to patient or to employer. The program for volunteer service and the rôle of the director of volunteer service are becoming more and more clearly defined. This is vital if a program is to be successful and to be useful. Almost as, if not equally, important is the need for orientation of staff and employes to the volunteer.

In most hospitals the director of volunteers meets with the administrator and department heads. Only in this way can the director be informed of where volunteers can be utilized and what the special departments' needs are. Opportunity should be given for the director of volunteers to explain the program she is responsible for to the personnel of each department where any of her workers may be placed. In this way the department workers are prepared to accept the volunteer as a co-worker and on a friendly basis. They will realize that the volunteer has her own job to perform, that she is not a substitute for the paid employe, and that together they are working to give better patient care. The use of trained volunteers who are serious about their work adds, according to an excellent hospital administrator, importance to the job of the hospital workers who feel their own positions have added importance when busy people give up time to come and work with them.

There should be distinct understanding by each department head that while the volunteer is at work in that department, she is her superior. If the department head finds that the volunteer is poorly placed and is not an asset, the director of volunteers should be informed. If it is part of the indoctrination of the volunteer that a particular placement may not always work out, that at times it is wise to rotate tasks or assignments, changes can be easily made without hurt feelings and without loss of job satisfaction. All volunteers work from the office of the director where they sign in and out.

The director of volunteers should have administrative ability, like and understand people, be able to communicate ideas, and have virtually unlimited patience. If she could be blessed with humor and tireless energy she might be a paragon of virtue, but she would be ideally fitted for the job. There seems to be universal agreement that the director is responsible for the interviewing and assignment of volunteers. She should screen, place and train her workers. Her program must have the approval of the administration and it must be accepted by the staff.

Good organization is a necessity if any volunteer service is to be successful. It takes rare judgment to turn intermittent workers into an organization that gives dependable service.

INTERVIEW IS IMPORTANT

The initial interview with an applicant for service is, in my opinion, all important. Failure to impress the volunteer with the obligations entailed and of the importance of her rôle in the hospital is, in no small measure, responsible for lack of understanding and regularity and for failure to observe rules and policies. It is essential that, from the beginning, definite amounts of time on definite days are agreed upon; that there be willingness to learn and to accept supervision. All this can be done so that when the application card is filled out, the volunteer leaves with a sense of privilege.

It is difficult to understand why we should be willing to be less exacting in our standards of performance from one who is a volunteer and is offering to do a job of her own free will and because of what it gives her by way of happiness and satisfaction than we are when somebody is doing it because she needs the weekly pay check. Volunteer service, today, is not an extra, but is part of our daily lives.

Mrs. Pinanski is a former chairman, National Committee on Hospital Auxiliaries, American Hospital Association, and a hospital trustee.

Condensed from a paper presented at the Hospital Auxiliary Workshop, Pennsylvania State University, July 1956.

President McIntosh of Barnard College was correct when she said: "Devoted mothers do a better job for their families if they also find some way of exercising their minds and talents outside their home."

Before placement, orientation sessions are held. It would be easier if these sessions could be given for several volunteers at once, but they should never be neglected. The aims and objectives of the hospital and its financial situation are pointed out. Need for volunteers is explained. Importance of the volunteer work is emphasized and interpreted in its relationship to patient care and creation of good will. Hospital ethics and the necessity for professional behavior are clarified. The person in charge of orientation also describes the satisfactions gained from conscientious service and the inspiration derived from friendly contacts.

Volunteers should realize that they must not initiate or extend services without approval of the director. While the director has by this time learned something of the applicant's interests, training and capabilities, it is worth while to point out that there are special abilities that can be utilized: A linguist may make a valuable contribution as the interpreter for a foreign-born family or a patient. It makes such a difference if someone is able to explain, even though haltingly, what the doctor or nurse has said—or what it is the patient wants them to know.

The director must have a constant inventory of positions to be filled, know the qualifications the volunteer must have for each job and a detailed written description of the work to be done. "You, too, can serve" might be the motto of the director, even though she must never accept volunteers more rapidly than they can be placed in useful activity. Nothing is more deadening to a serious, well intentioned volunteer than to be assigned to doing needless work because of poor planning or poor supervision.

Routine jobs can be planned to interest the most intelligent and scholarly if they are interpreted in terms of end results and alleviation of human suffering. Checking of answers to "patient follow-up questionnaires" becomes a job that is fun if the negative responses to "Was food served attractively?" result in more attention to serving and preparation of food in the diet kitchen. Many a volunteer who drops out from lack of interest is a recorded failure simply on account of lack of realization of over-all objectives, of the necessity of team play, of wastage of special abilities.

Placement of volunteers is made more effective, too, by education for the job. In a large volunteer service program, it is an excellent idea to select skilled volunteers as the chairmen for specific branches, *i.e.* patient library service, ward secretaries, admitting office, information service, blood donors, coffee shop, gift shop, baby pictures, etc. Each chairman will meet the new volunteer, introduce her to other members of the same service, and work with her in the particular position so that she does not become a burden to the professional staff during indoctrination. These chairmen may hold an occasional meeting of all their volunteers. It can be a social tea, but opportunity is given to make suggestions for improved service, to offer criticism, to discuss problems. In turn, the director of volunters may meet with all her chairmen and follow the same program—and she then may have some points to take up with the administration. Such a program facilitates and improves the service, develops loyal workers, cultivates leadership, and recruits volunteers for responsible duties.

Constant supervision pays dividends in the end and results, too, in satisfactory assignments that stimulate interest and present challenges to the worker. The volunteer leaves with a sense of pride in her work. She realizes she is not a substitute for a professional worker but is doing a job of her own in her own field.

There is a growing tendency to use volunteers in wider directions. Social service is finding that the case work aide is invaluable if she is properly trained. Under the auspices of the United Hospital Fund of New York a special program for volunteer case aides in medical social service was set up. The manual which was developed is available to any hospital wishing to inaugurate such a program.

As medicine develops an increasingly psychotherapeutic outlook, opportunities develop for volunteers to take part in the hospital program. The admitting office, which has long had difficulties in its public relations contacts, has become humanized since the introduction of volunteer receptionists who bring warmth and friendliness to entering patients or their families as they wait their turn for admission. After the formal procedures are attended to, they escort the patient to the floor, introduce him to the nurse in charge, and leave with a friendly greeting. This service often releases the tension of a frightened and unhappy patient and paves the way for a more relaxed hospitalization.

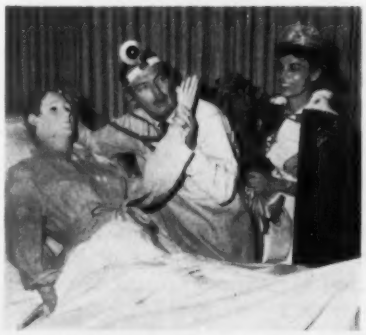
The volunteers who serve a cup of coffee to the tense family waiting anxiously for a report from the operating room create an atmosphere of personal interest in the patient and his family that overworked professional personnel can rarely find time for. "Mended Hearts," who have taken a course in visiting, see prospective patients about to undergo heart surgery, on the surgeon's request, and help alleviate the anguish and fear of many a patient. Dr. Dwight Harken, one of the pioneers in heart surgery, feels

"Queen for a Day" Promotes Recruitment

"This patient is not well!"

Jack Bailey, Hollywood's Queen for a Day emcee, is shown clowning, as a newly crowned "queen"—Student Nurse Erma Baker of the College of Medical Evangelists, Los Angeles—watches, dazed but smiling. Erma was one of 700 nurses and students who crowded the Queen show recently in a special program to promote nurse recruitment.

Erma Baker's problem: She needed a baby sitter while she finished her final year of nursing school and her husband, Calvin, attended medical school. At 27 she's the mother of three. Her prize included nursing uniforms, wardrobe, her own "Mrs. Chase" (shown in the picture), a color TV set, and a trip to Europe, where she'll present greetings from America's nurses.



Jack Bailey takes Mrs. Chase's pulse while Student Queen Baker looks on.

that these visits of volunteers, who have undergone similar surgery, is a major factor in the faster recovery of his patients.

Then there is an equally fine group of former patients, known as the QT Club, who help in the adjustment of other patients who have undergone ileostomies or colostomies and who have a radical readjustment to make.

Volunteers, undoubtedly, bring a continuing personal contact with the outside world and help motivate a patient's recovery. The art of visiting patients can be taught, as can the skill of handling different kinds of people. One hospital, I know, is building better patient relationships through the visits of exceptionally skillful women who call to ask for suggestions for improving care. It's wonderful how therapeutic just being able to tell your complaints can be.

VOLUNTEERS PROVED DEVOTION

In Boston during the dreadful polio epidemic of last year, with nurses working often in 18 to 24 hour shifts, volunteers proved their ability and their devotion. I saw women who would, in normal times, keep away from you if you had a cold, who turned up at the polio wards of Boston hospitals to feed babies and respirator cases at breakfast, at lunch, at dinner, who made hot packs, helped bathe patients, kept clinical charts, cared for convalescents, helped amuse children and grown-ups. There was never a shortage of dependable, hard-working volunteers and, when electricity went out during a hurricane, men volunteers appeared as if by magic to pump hand-operated respirators. These people asked for no recognition, but a grateful community honored them.

New sources of recruiting volunteers have been and are developing. Even the children in elementary schools are being indoctrinated, if you will, with the love of their fellow-man, as a third grade is told of the helpless children in a state institution and it adopts a room and sends these children valentines, Christmas cards, holiday favors and the like. They learn how much a Christmas card or birthday greeting can mean to the inmate of a home for the aged or to the chronically ill in a city hospital. This is one of the new trends in the thoughtful use of volunteer efforts.

Somewhere I read, but failed to note who wrote it: "It's the little things around the hospital that make the big difference with the patient and the public." These are the things we are hoping our volunteers will find time to do, to give, to help with. In the same article appears: "Everybody likes to feel that he is somebody; don't you? The school boy comes home some day feeling mighty happy—just because the teacher made him feel important. You must remember the patient is sick and needs all the kindness and help he can get, and all the wonder drugs and scientific equipment can't replace these needs. Treat people as you would like to have them treat you." It's this warm human understanding that we are looking for in volunteers.

Perhaps that is why doctors who are interested in the welfare of our retired workers are most enthusiastic about using volunteer services from the therapeutic point of view in some instances but, equally important, from the point of view of the hospital in preventing waste of the skills of men and women who can make an invaluable contribution to human welfare. Unless we seek the abilities of such people and find them opportunities, we are losing one of the greatest sources of dependable volunteers.

In the pharmacy of one of Boston's great hospitals, for example, a retired professor of chemistry comes each day and works on Saturdays, Sundays and holidays as well; a retired librarian, as a volunteer, serves the student nurses' library and a colleague of hers is, at last, producing a well catalogued patients' library; an expert accountant assists in the business office; a biology teacher gets a new motive for going on in the cancer research department. At Peter Bent Brigham Hospital's gift shop there is a great demand for the pictures painted by a 75 year "young" woman—which she insists on donating for sale in the gift shop as a tribute to what the hospital's geriatric service has done for her.

The work these folk old in age, but still as youthful in spirit and ability as ever, can do is one of the newest trends in utilizing services of volunteers. They are not depriving workers of jobs, but they are helping the hospital give more and better service. Their gift of themselves is greater even than what they do, for they know how much their coming can mean to those who are sick, lonely or handicapped.

One cannot possibly discuss trends in the volunteer program or in the training of volunteers without a few words about the development of the program of service in the psychiatric wards of general hospitals and in the state mental institutions. This has great significance not only in terms of what it accomplishes, but in the roads it points out in the use of volunteers.

The volunteers tend to increase the sense of security for the patient. Their kindliness, friendliness and human warmth carry over so that the patient senses he has a place in human society and begins to feel less lonely, isolated and withdrawn. The gap between the patient and the outside world is bridged by this friendship, this acceptance, and often the volunteer parties, the trips outside the institutions, reestablish for the patient contact with society, with his family and his neighbors.

IT IS A DEDICATED TASK

Just a brief word in conclusion. At the American Hospital convention in Chicago in 1954, Dr. Harold Blake Walker, a Presbyterian minister, was the closing speaker. His address made an impact on me that I have never forgotten. He told the story of a man in the play "Morning's at Seven." Carl was a dentist who suffered periodically from what the family politely called "spells." When he had one of these attacks, he wandered around the neighborhood asking everybody he met, "Where am I?" Now, physically he knew where he was, but the question he really asked was "Where am I after 60 years of living? What have I accomplished? Where am I intellectually, morally and spiritually? What have I done with myself?" I am resolutely putting aside the temptation to quote his whole address—to me it had and has a great message in the terms of life. Volunteer service is not just a way to use odd moments. It is successful only if it is a dedicated task—then it is a way of life that makes us conscious of God's plan. May I say that the oldest yet the newest trend in the training of volunteers for those of us who lead is to interpret volunteer service in the terms of dedication and rededication to our fellowmen.

Dean Inge says in his book "Personal Religion and the Life of Devotion": "The joy of achievement is the recognition of tasks understood and done. To do our duty in our own sphere, to try to create something worth creating as our life's work is the way to understand what joy is in this life."

PROTOTYPE STUDY: 200 BED HOSPITAL

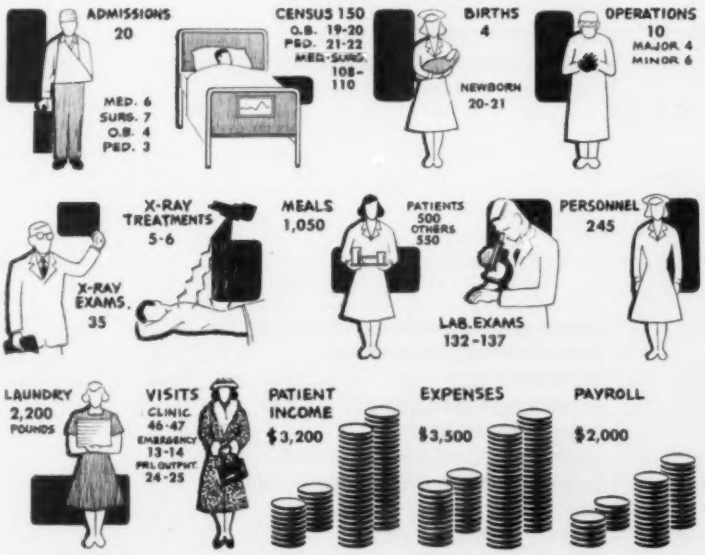
Continuing a new series of "prototype studies" of hospital operations and activities, with up-to-date information on principal departments

This expanded prototype study of the 200 bed hospital analyzes operations in greater detail than has ever been done before. The prototype study becomes a useful tool for self-evaluation by hospitals in this size group, and a guide to administrative planning. Subsequent studies will present similar detailed information describing hospitals in the larger size groups

LOUIS BLOCK, Dr. P.H.
Chief, Research Grants Branch
Division of Hospital and Medical Facilities
Public Health Service, Washington, D.C.

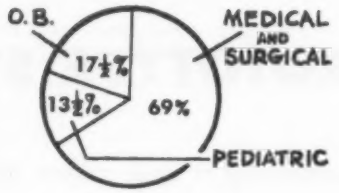
AN AVERAGE DAY'S ACTIVITIES

In this prototype of hospital operation for the 200 bed nonprofit, general hospital, national data were used whenever available. Regional, state or special group information was adjusted to the national basis. This represents the composite or average of existing statistical data. As new or more refined information becomes available, the content may need revision. It does not generally reflect affiliated services with other hospitals and sources; nor does it necessarily indicate the ideal institution.



BED DISTRIBUTION

In more than half of these hospitals, medical, surgical, obstetrical and pediatric patients have beds specifically set aside for their use. For this reason they are considered as major services to such a hospital type and size group. The foregoing bed distribution will be affected by assignments to additional services discussed hereafter:



In addition to the basic grouping of patients found in more than half of these hospitals, the 200 bed, nonprofit, short-term, general hospital may make specific bed assignments for other patient groups. Because they occur in less than half of these hospitals they are considered as additional service grouping. The following shows these additional service groupings, the frequency of their occurrence, and the average number of beds assigned them:

ISOLATION OR CONTAGIOUS PATIENT BEDS—

a. Frequency of occurrence.....1 in 5 hospitals
b. Average number of beds assigned..... 9

CHRONIC (LONG-TERM) PATIENT BEDS—

a. Frequency of occurrence.....1 in 14 hospitals
b. Average number of beds assigned.....20

NERVOUS AND MENTAL PATIENT BEDS—

a. Frequency of occurrence.....1 in 10 hospitals
b. Average number of beds assigned.....21

TUBERCULOSIS PATIENT BEDS—

a. Frequency of occurrence.....1 in 25 hospitals
b. Average number of beds assigned.....24

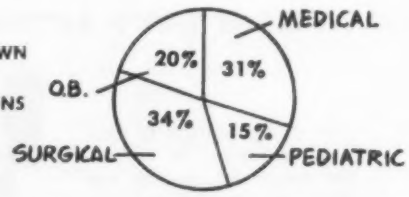
UTILIZATION

The kind, type and number of patients admitted to and using the 200 bed general hospital are as follows:

Annual number of adult admissions	7300
Annual number of admissions per bed	36-37
Annual number of live births	1400
Annual number of premature births	85
Annual number of stillbirths	18
Annual number of sets of twins	14
Annual number of sets of triplets	1
Annual number of patient days of care	54,750-55,000
Annual number of obstetrical days of care	7000
Annual number of pediatric days of care	8000
Annual number of medical-surgical days of care	40,000
Annual number of newborn infant days of care	7500
Average daily adult census	150
a. Medical-surgical	108-110
b. Obstetrical	19-20
c. Pediatric	21-22
Average daily newborn census	20-21
Percentage of adult occupancy	75
a. Medical-surgical	80
b. Obstetrical	70
c. Pediatric	63
Percentage of newborn occupancy	60
Average length of patient stay	7.5 days

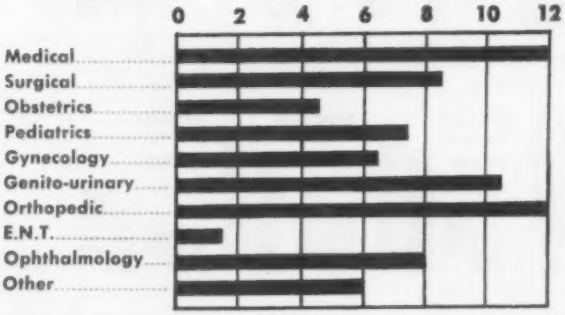
AVERAGE LENGTH OF PATIENT STAY BY ACCOMMODATION:

BREAKDOWN OF ADMISSIONS



* (Semiprivate patients usually stay a shorter time than do either private or ward patients. Among the usual explanations for such an occurrence is that the pressure of finances requires the semiprivate patient to get back to gainful employment as soon as possible. Private patients may be in a better position to afford slightly longer convalescence in the hospital. Ward patients, on the other hand, may have other factors dictating or affecting the length of time they stay. Among these factors are usually those of more advanced cases of illness and home conditions not conducive to convalescence.)

AVERAGE LENGTH OF PATIENT STAY BY DIAGNOSIS:

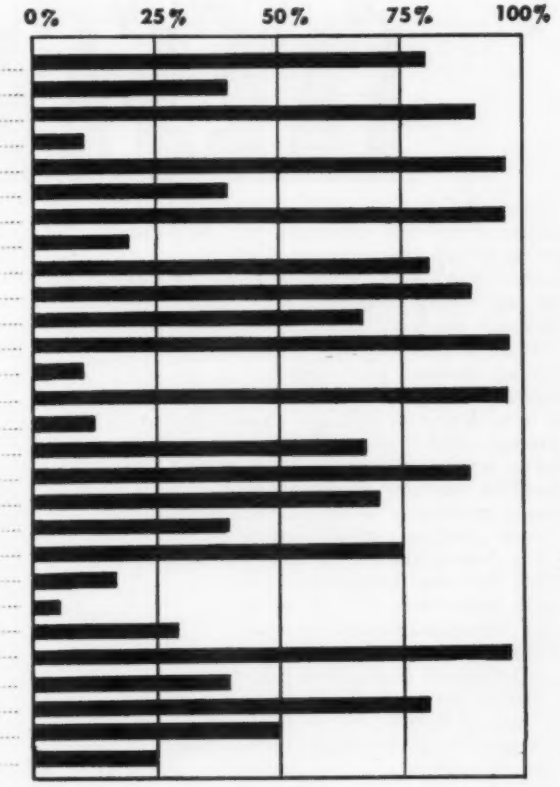


PERCENT OF PATIENTS DISCHARGED BY LENGTH OF STAY:

	Per Cent	Cumulative
1 day	8	8
2 days	12	20
3 days	10	30
4 days	11	41
5 days	12	53
6 days	10	63
7 days	6	69
8 days	5	74
9 days	3	77
10-13 days	10	87
14-20 days	7	94
21-30 days	3	97
31 days and over	3	100

SERVICES

Services that might be provided but which are generally found to occur in less than 50 per cent of the facilities of this size group are considered as additional. Certain of these services may be provided through arrangements with other hospitals and sources. Such arrangements are not reflected in the frequencies shown.

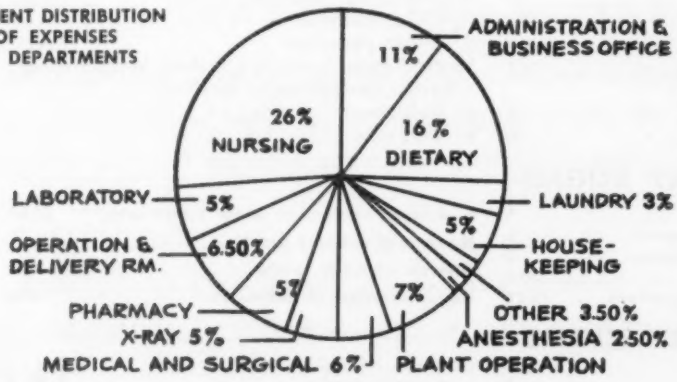


Frequency of hospitals offering:

- Blood bank
- Cancer clinic
- Central supply room
- Children's educational program
- Clinical laboratory
- Dental department
- Electrocardiograph
- Electroencephalograph
- Hospital auxiliary
- Library, medical
- Library, patient
- Medical records department
- Mental hygiene clinic
- Metabolism apparatus
- Occupational therapy department
- Outpatient department
- Pharmacy
- Physical therapy department
- Postoperative recovery room
- Premature nursery
- Radioactive isotopes
- Rehabilitation department
- Social service department
- X-ray diagnosis
- X-ray, routine chest on admission
- X-ray therapy service
- School of nursing
- Organized training programs for auxiliary nursing personnel

FINANCIAL

PER CENT DISTRIBUTION OF EXPENSES BY DEPARTMENTS

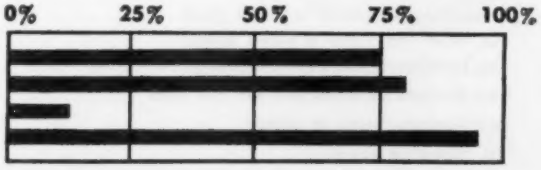


Total assets	$2,450,000
Total assets per bed	$ 12,250
Plant assets	$1,750,000
Plant assets per bed	$ 8,750
% plant assets of total assets	72
Total annual expenses	$1,270,000
Total expenses per pat. day	$ 23.25
Average exp. per pat. stay	$ 175
Annual payroll	$ 745,000
Payroll per patient day	$ 13.60
% payroll of total expenses	59
Total annual income	$1,300,000
Total income per pat. day	$ 23.75
Annual patient income	$1,175,000
Patient income per pat. day	$ 21.50
% pat. income of total inc.	92

NURSERY

NUMBER OF BASSINETS 34

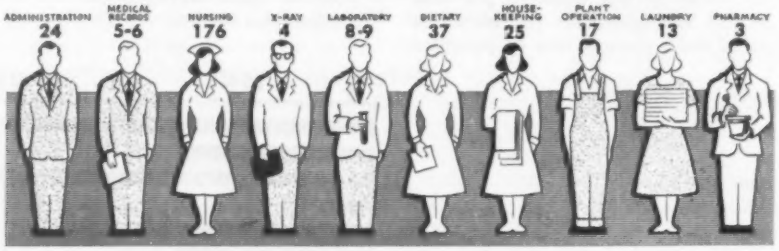
- Hospitals having special nurseries for premature infants
- Hospitals using bead bracelets for identification
- Hospitals using tape bracelets for identification
- Hospitals having infant incubators*



*Average number per hospital....5-6

PERSONNEL

DEPARTMENTAL DISTRIBUTION OF PERSONNEL:



Number of full-time personnel	312
Number of full-time personnel per 100 patients	212
Number of full-time employes per bed	1.5-1.6
Number of full-time employes per occupied bed	2.1
Hospitals having volunteers other than women's auxiliary	3 in 5
For those hospitals having volunteers, average number per hospital	55
Hospitals having a women's auxiliary	4 in 5
For those hospitals having women's auxiliary, average number of members per hospital	475
Average number of members of women's auxiliary working in the hospital	113
Nursing personnel:	
a. Total graduate nursing personnel	88
(1) Administrative graduate nursing personnel	3
(2) Full-time instructors	4
(3) Supervisors and assistants	8
(4) Head nurses and assistants	12
(5) General duty nurses full-time	43
(6) General duty nurses part-time	18
b. Private duty nurses	14
c. Practical nurses	31-32
d. Attendants (in hospitals that have them)	25
e. Nurse's aides	44
f. Ward maids	7-8
g. Orderlies	16-17
Medical technologists:	
a. Registered full-time	4
b. Registered part-time	0-1
c. Other full-time	4
d. Other part-time	1
X-ray technicians:	
a. Registered full-time	2
b. Registered part-time	0
c. Other full-time	2
d. Other part-time	0
Pharmacists (in those hospitals having a pharmacy department):	
a. Full-time	1-2
b. Part-time	0
Medical record librarians (in those hospitals having a medical records department):	
a. Registered full-time	1
b. Registered part-time	0
c. Other full-time	1
d. Other part-time	0
Other medical records personnel (in those hospitals having a medical records department):	
a. Full-time	3
b. Part-time	1
Dietitians:	
a. Full-time	2-3
b. Part-time	0
Occupational therapists (in those hospitals that have an occupational therapy department):	
a. Registered full-time	1
b. Registered part-time	0
c. Other full-time	0
d. Other part-time	0
Physical therapists (in those hospitals that have a physical therapy department):	
a. Registered full-time	1
b. Registered part-time	0
c. Other full-time	1
d. Other part-time	0
Medical social workers (in those hospitals that have a medical social service):	
a. Full-time	2
b. Part-time	0

OPERATING AND DELIVERY ROOMS

Number of operating rooms	5
a. Number of major operating rooms	3
b. Number of minor operating rooms	2
Annual number of operations	3675
a. Annual number of major operations	1525
b. Annual number of minor operations	2150
Number of delivery rooms	2
Number of labor rooms	2
Annual number of deliveries	1400

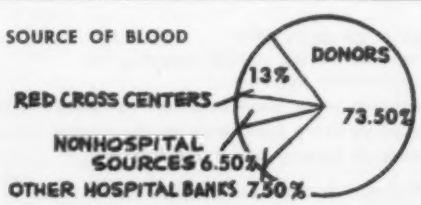
POSTOPERATIVE RECOVERY ROOMS

Number of recovery beds	7
Hospitals having postoperative recovery rooms	2 in 5

BLOOD BANK

Hospitals that have a blood bank	4 in 5
In those that have a blood bank:	
a. Number of units (500 cc.) issued annually	1171
b. Number of units per bed per year	5.9
c. Average stock in units	31-32
d. Bleeding capacity	3

SOURCE OF BLOOD



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A BETTER TECHNIQUE FOR PATIENT UTENSILS . . .

THE *American* UTENSIL WASHER-SANITIZER

• The American Utensil Washer-Sanitizer provides efficient equipment to carry out an improved technique in preventing the transfer of communicable diseases among patients and hospital personnel. Convenient and automatic, it washes and sanitizes three full sets of patients' utensils in two loads . . . at a speed well within the normal discharge-and-admission rate. Simple and economical to install and operate, the Washer-Sanitizer saves personnel time, reduces Utility Room clutter and assures uniform cleaning and sanitizing at less cost.

For complete information on this new Utensil Technique, write for bulletin SC-321.

The American Utensil Washer-Sanitizer is available with stainless steel Utility Room clean-up counter or as the free-standing unit shown above.

AMERICAN STERILIZER
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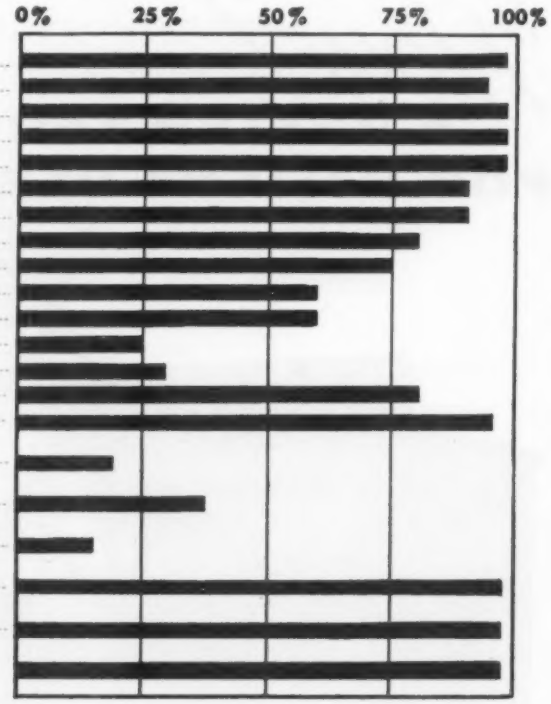
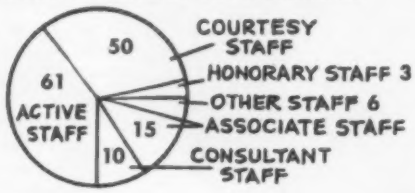
MEDICAL STAFF

Frequency of hospitals having:



- CHIEF OF STAFF
- CHIEFS OF SERVICES
- WRITTEN STAFF REGULATIONS
- REGULAR STAFF MEETINGS
- STANDING STAFF COMMITTEES
- EXECUTIVE STAFF COMMITTEE
- MEDICAL RECORD COMMITTEE OF STAFF
- CREDENTIALS COMMITTEE OF STAFF
- TISSUE COMMITTEE OF STAFF
- EDUCATION COMMITTEE OF STAFF
- PHARMACY COMMITTEE OF STAFF
- DIETARY COMMITTEE OF STAFF
- NURSING COMMITTEE OF STAFF
- PSYCHIATRIST ON STAFF
- SURGICAL RESTRICTIONS ON STAFF
- PERMITTING NONSTAFF MEMBERS TO PRACTICE IN HOSPITAL
- PROVIDING EXAMINING ROOMS FOR AMBULATORY PATIENTS OF MEDICAL STAFF
- PRIVATE PHYSICIANS' OFFICES IN HOSPITAL OR ON HOSPITAL GROUNDS
- X-RAY FACILITIES AVAILABLE TO PRIVATE AMBULATORY PATIENTS OF STAFF
- LABORATORY FACILITIES AVAILABLE TO PRIVATE AMBULATORY PATIENTS OF STAFF
- RECEIVED ACCREDITATION BY THE JOINT COMMISSION OF HOSPITAL ACCREDITATION

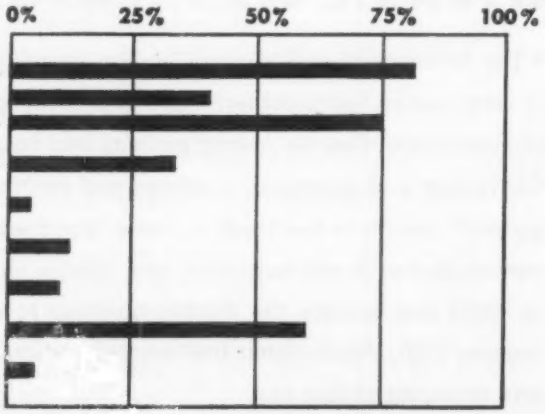
145 STAFF PHYSICIAN APPOINTMENTS



PER 100 BEDS

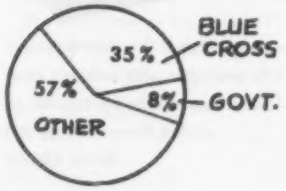
ACTIVE STAFF	30-31
ASSOCIATE STAFF	8
COURTESY STAFF	25
CONSULTANT STAFF	5
HONORARY STAFF	1-2
OTHER STAFF APPOINTMENTS	3

ACCOUNTING



- Hospitals which calculate depreciation
- Hospitals which operate under formal budgets
- Hospitals which use A.H.A. chart of accounts
- Hospitals which fund depreciation (of those hospitals which calculate depreciation)
- Hospitals which have inclusive rate for all patients
- Hospitals which have inclusive rate for obstetrical patients
- Hospitals which have inclusive rate for tonsillectomy patients
- Hospitals which charge for drugs carried in stock on nursing unit
- Per cent of hospital billed income which is considered uncollectible

% OF BILLED CHARGES PAID



STARTING MONTHLY SALARY:

General duty nurse	$244
Untrained women	134
Untrained men	157
Clerks	168
Practical nurse	172

HOURS OF WORK PER WEEK:

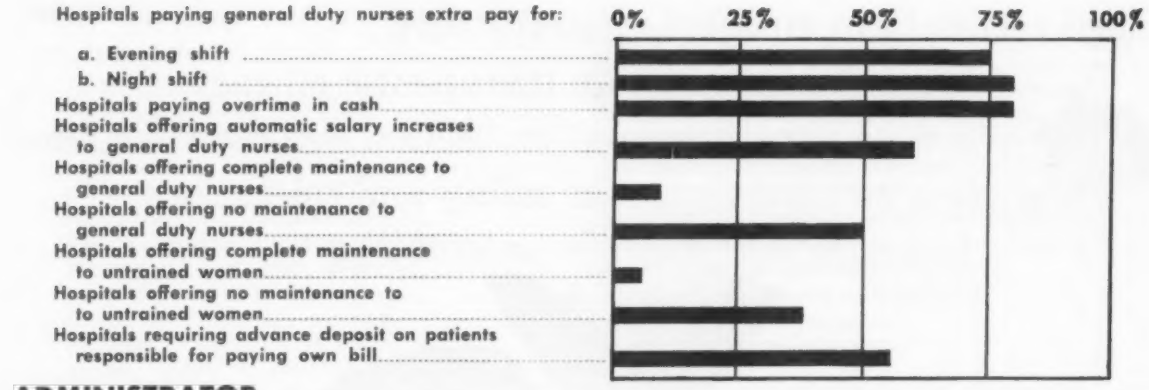
General duty nurse	41
Untrained women	43

AVERAGE ROOM RATES:

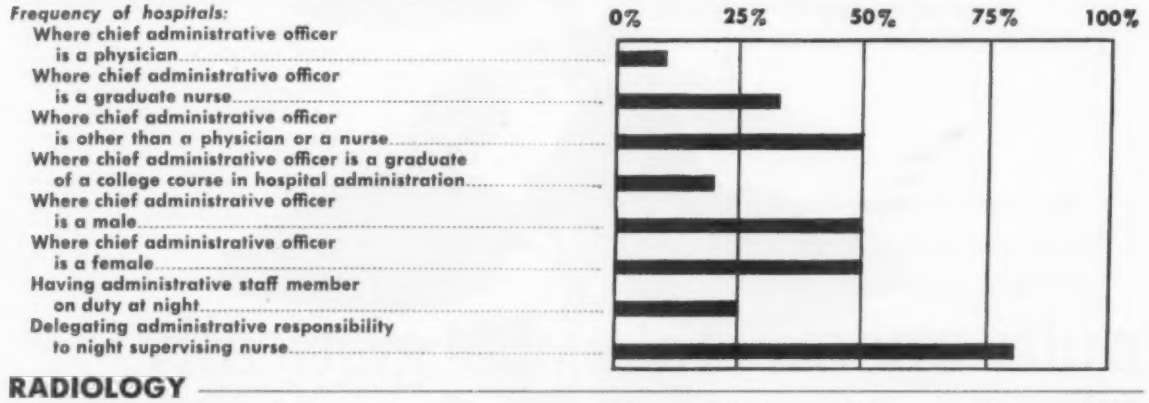
One person room	$15.35
Two person room	12.20
Multibed room	10.25

AVERAGE DAYS OF VACATION AFTER ONE YEAR OF EMPLOYMENT:

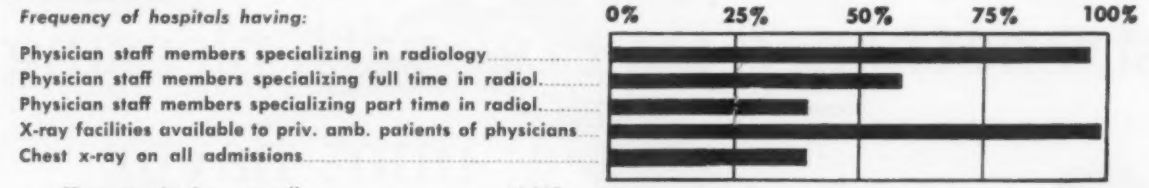
General duty nurse	15
Untrained women	12



ADMINISTRATOR

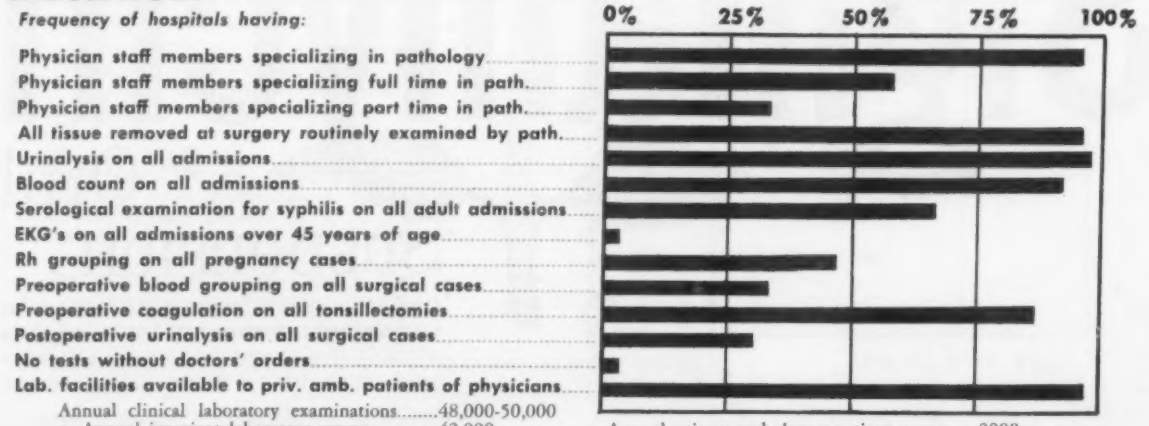


RADIOLOGY



X-ray examinations, annually 13,000
a. Annual inpatient x-ray exams 7750
b. Annual outpatient x-ray exams 3500
c. Annual priv. amb. patient x-ray exams..... 1750
X-ray therapy treatments 2000

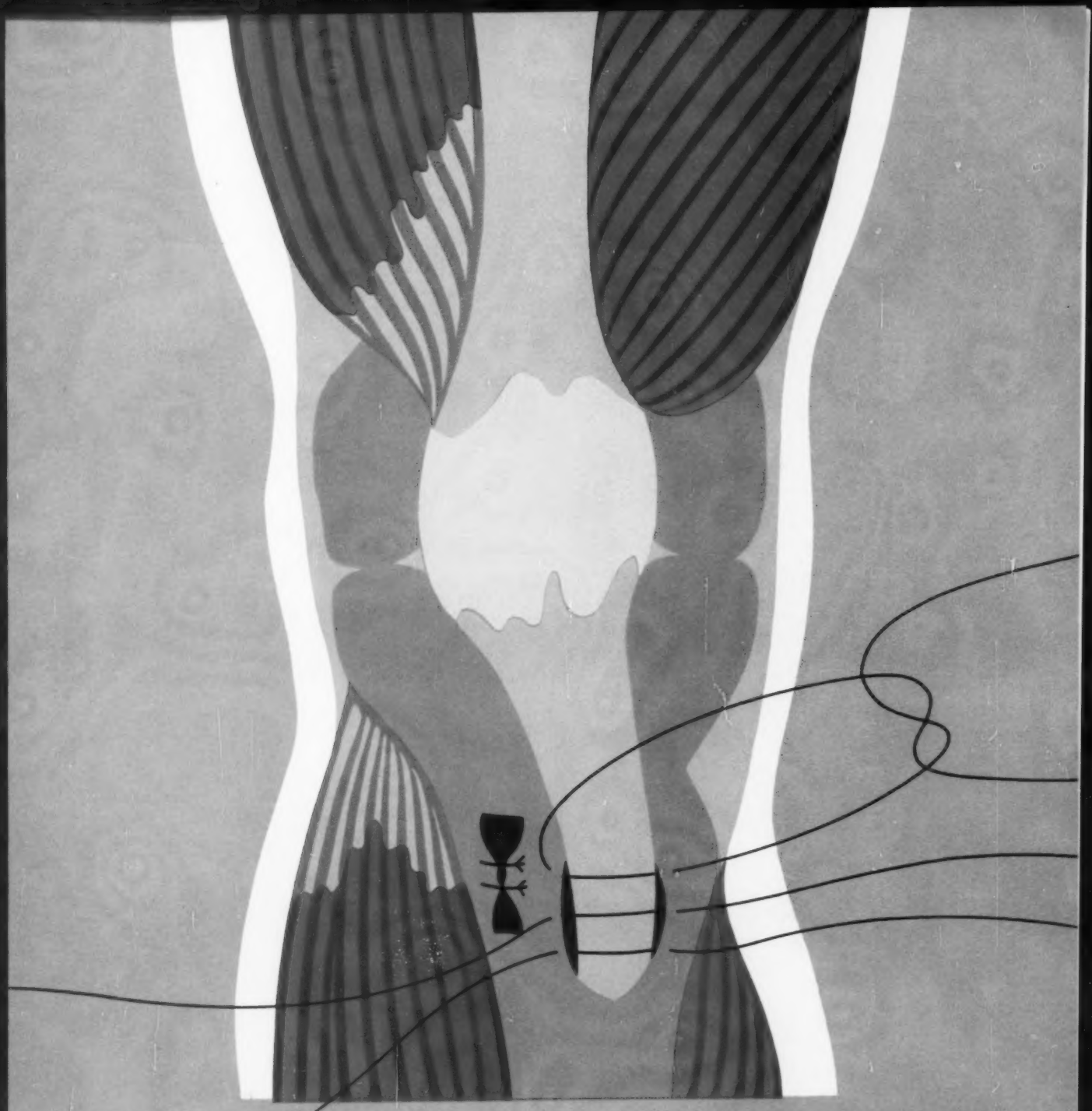
LABORATORY



Annual clinical laboratory examinations..... 48,000-50,000
a. Annual inpatient laboratory exams 42,000
b. Annual outpatient laboratory exams..... 6000
c. Annual private ambulatory patient exams.... 2000
Examinations per patient per day..... 0.7-0.8

OUTPATIENT DEPARTMENT

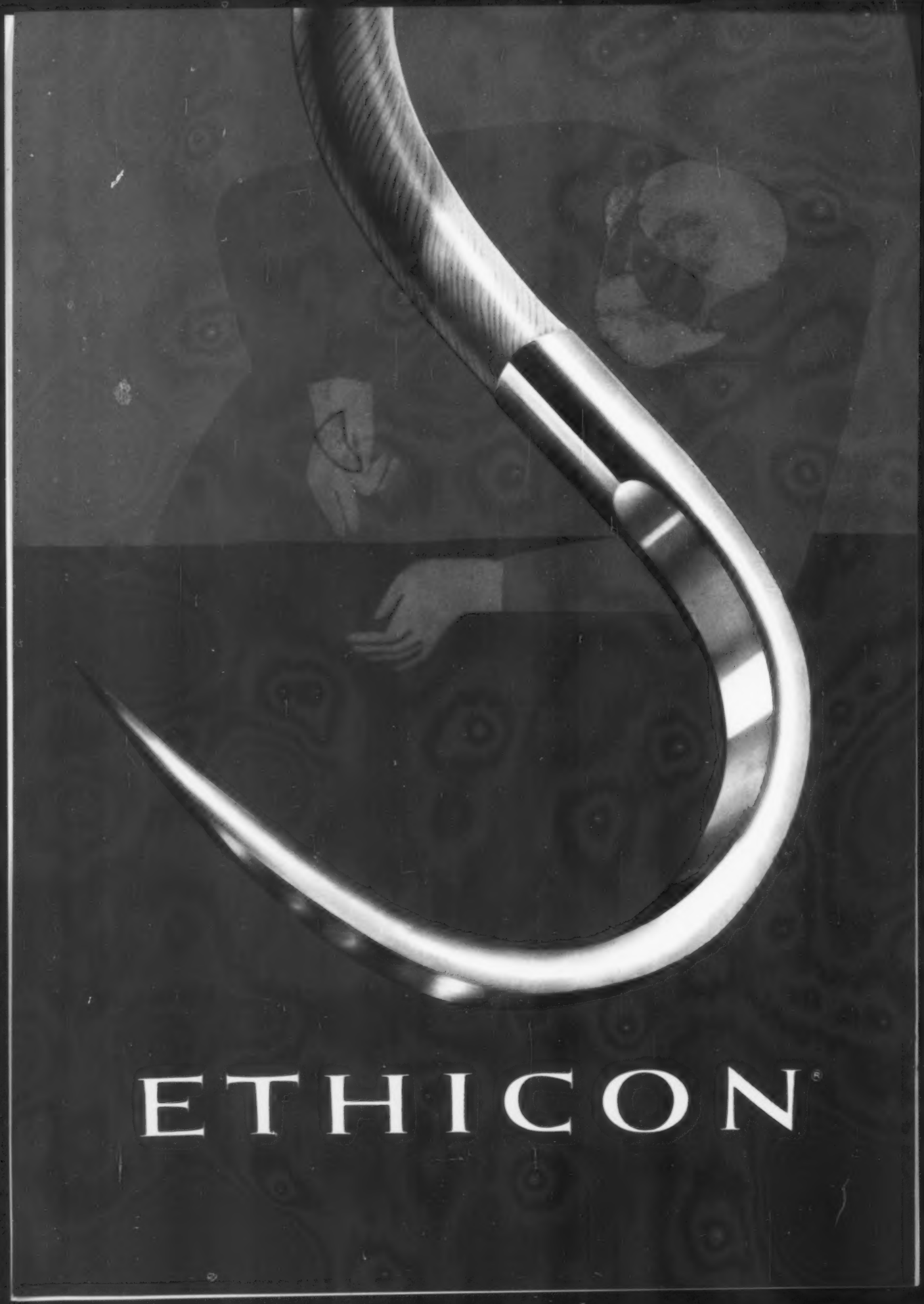
Number of annual clinic visits..... 17,000-17,100
Number of annual private outpatient visits 8700-8800
Number of annual emergency visits.. 4800
Per cent of emergency patients admitted to the hospital as inpatients..... 9-10



setting new standards

ETHICON®

sutures


ETHICON®

PHARMACY

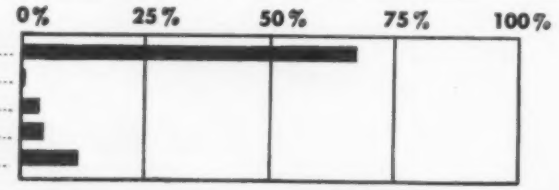
Hospitals having formulary ..... 3 in 5
Hospitals operating pharmacies ..... 9 in 10
Of those hospitals operating pharmacies, having full-time licensed pharmacist ..... 9 in 10
Of those hospitals having a full-time pharmacist, average number 1-2
Of those hospitals operating pharmacies, manufacturing parenteral solutions ..... 1 in 16

MEDICAL RECORDS

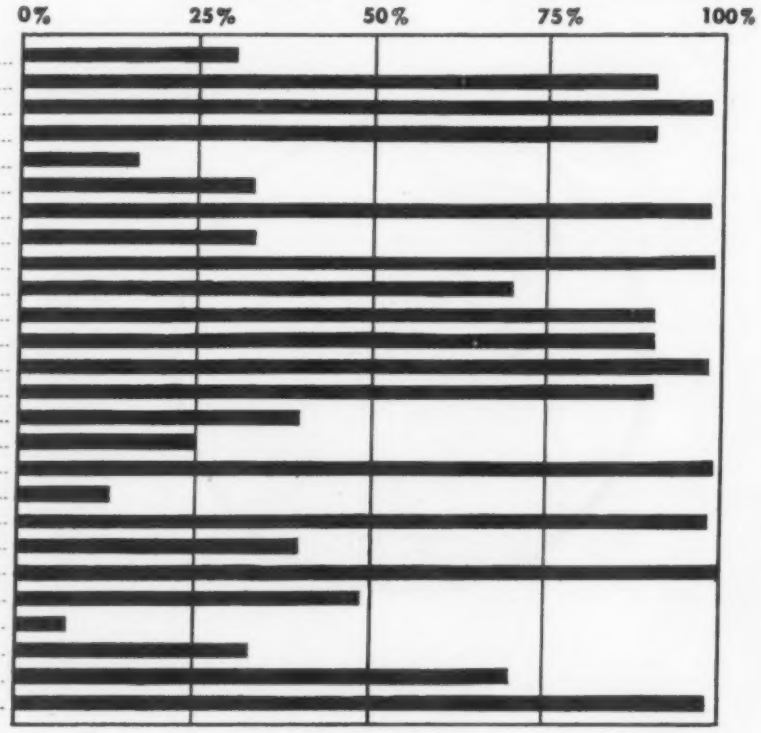
Hospitals microfilming medical records ..... More than 1 in 3
Number of annual deaths 197
Per cent deaths of admissions 2.8
Number of annual autopsies 70-71
Per cent autopsies of deaths 35
Number of annual deaths released to legal authorities 21
Per cent such deaths (6) of admissions 0.3
Hospitals using standard nomenclature of diseases and operations ..... Almost all

ADMITTING

Frequency of hospitals:



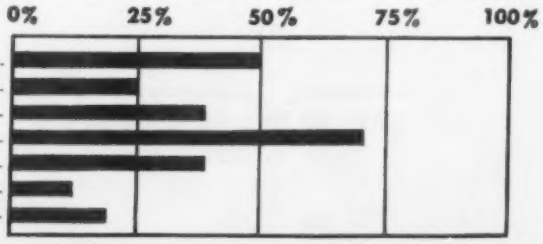
Routinely treating:



Admitting psychiatric patients ..... 1 in 4
Of those general hospitals admitting psychiatric patients:
a. Caring for such patients in separate buildings ..... 1 in 18
b. Caring for such patients in separate departments in same building ..... 1 in 3
c. Caring for such patients in no separate facilities ..... 3 in 5

RELIGIOUS

Frequency of hospitals with:



Each SUR-BEX with C tablet contains:

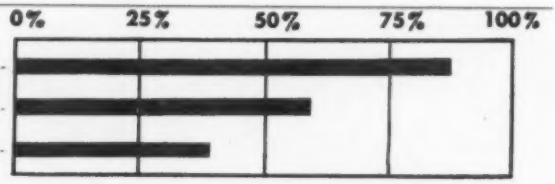
Thiamine Mononitrate	6 mg.
Riboflavin	6 mg.
Nicotinamide	30 mg.
Pyridoxine Hydrochloride	1 mg.
Vitamin B_{12} *(as cobalamin concentrate)*	2 mcg.
Calcium Pantothenate	10 mg.
Ascorbic Acid	150 mg.
Liver Fraction 2, N. F.	300 mg. (5 grs.)
Brewer's Yeast, Dried	150 mg. (2½ grs.)

As a dietary supplement: 1 or 2 tablets daily.
For stress, or postoperative convalescence: 2 or more tablets daily.

Abbott

PURCHASING

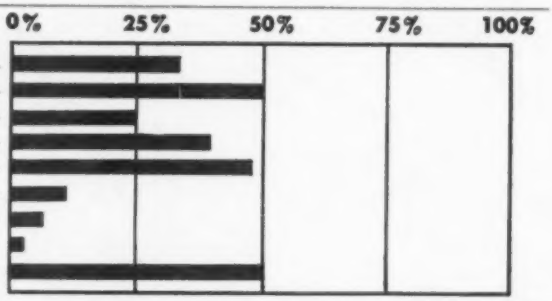
Frequency of hospitals with:



- Central purchasing department
- Full-time purchasing agent (of those hospitals with central purchasing department)
- Part-time purchasing agent (of those hospitals with central purchasing department)

PUBLIC RELATIONS

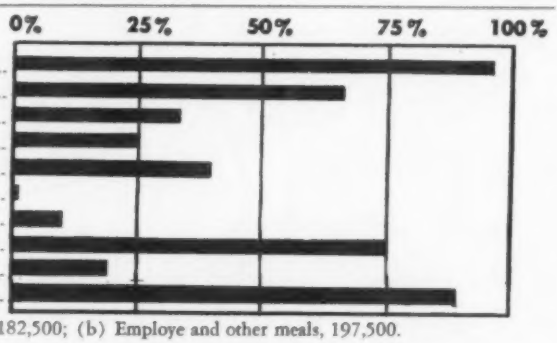
Frequency of hospitals using:



- BOOKLET FOR EMPLOYES
- BOOKLET FOR PATIENTS
- REGULARLY PUBLISHED HOUSE ORGAN
- PRINTED ANNUAL REPORT
- PATIENT OPINION POLL
- PERSONNEL OPINION POLL
- MEDICAL STAFF OPINION POLL
- COMMUNITY OPINION POLL
- USING NO SUCH POLL

DIETARY

Frequency of hospitals with:



- FULL-TIME DIETITIANS
- CENTRAL FOOD SERVICE LAYOUT
- SELECTIVE MENUS FOR ALL PATIENTS
- SELECTIVE MENUS FOR PRIVATE PATIENTS ONLY
- NO SELECTIVE MENUS
- MANUAL AND CENTRALIZED DISHWASHING
- MANUAL AND DECENTRALIZED DISHWASHING
- MECHANICAL AND CENTRALIZED DISHWASHING
- MECHANICAL AND DECENTRALIZED DISHWASHING
- GAS AS FUEL USED FOR COOKING

Number of meals served annually, 380,000; (a) Patient meals, 182,500; (b) Employe and other meals, 197,500.

LAUNDRY

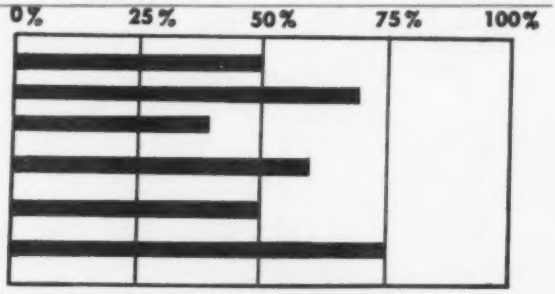
Hospitals which operate own laundry and process all soiled linen ..... Almost 9 in 10
- a. Number of lbs. processed per wk... 15,250-15,500
- b. Number of lbs. processed per patient day 14-15
- c. Number of lbs. processed per yr... 793,000-806,000

Hospitals which operate own laundry and process only a part of soiled linen ..... 1 in 25
- a. Number of lbs. processed per wk... 14,000-14,250
- b. Number of lbs. processed per patient day 14

Hospitals which do not operate own laundry ..... 1 in 10
- a. Number of lbs. processed per wk... 10,500-10,750
- b. Number of lbs. processed per patient day 10-11

SAFETY

Frequency of hospitals with:

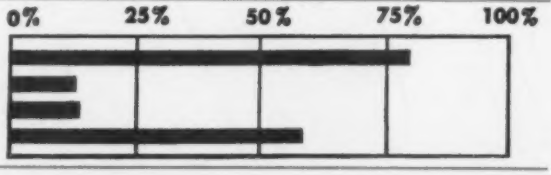


- ORGANIZED SAFETY COMMITTEE
- WRITTEN FIRE EMERGENCY AND EVACUATION PLANS
- REGULARLY SCHEDULED FIRE DRILLS
- OWN WRITTEN PLAN FOR MOBILIZATION OF EMPLOYES AND MEDICAL STAFF
- WRITTEN MOBILIZATION PLAN INTEGRATED IN MASTER COMMUNITY PLAN
- REPRESENTATION ON A COMMUNITY DISASTER PLANNING COMMITTEE

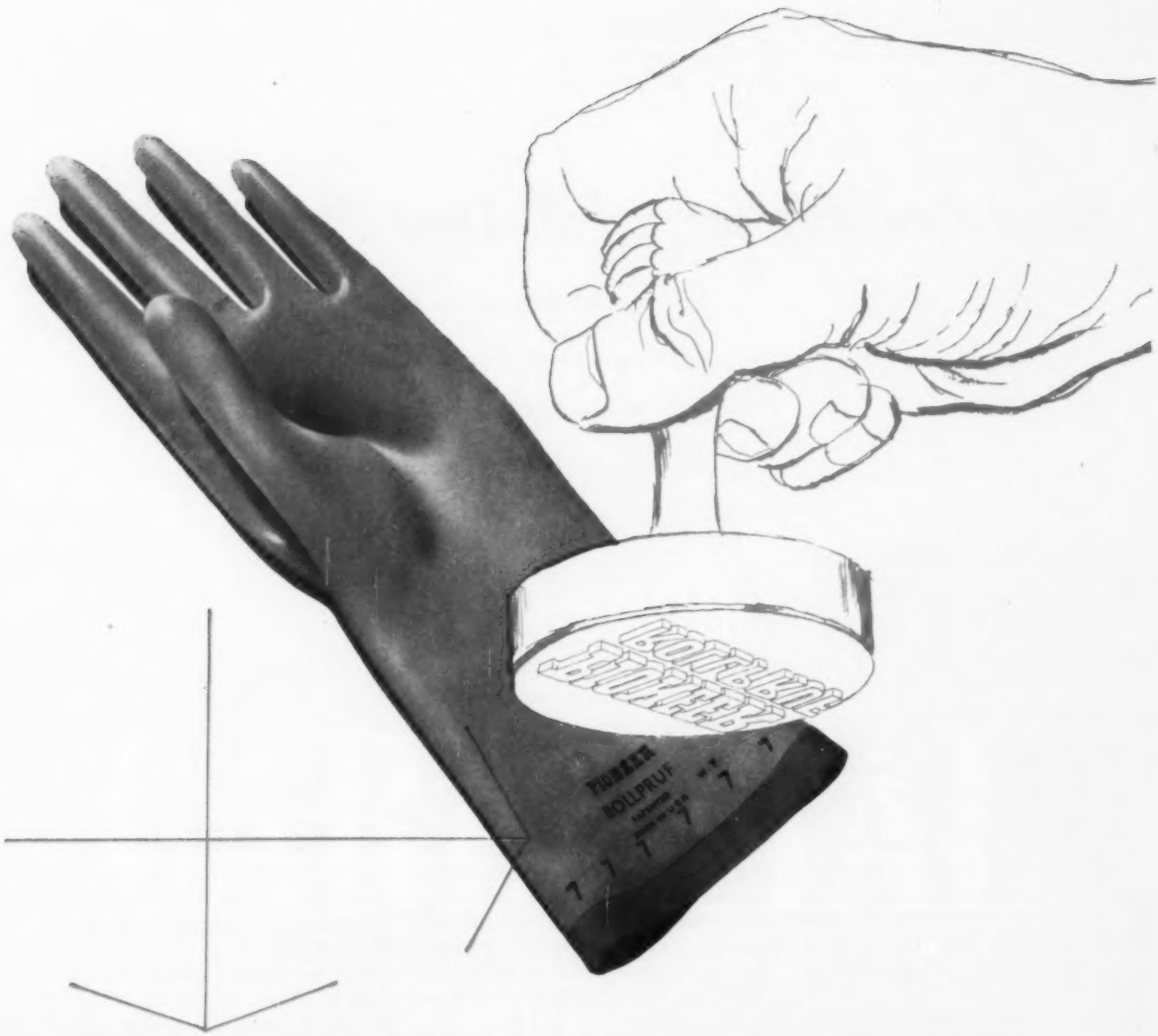
Number of injuries per million hours of exposure (work), 10.45. Annual number of injuries, 47: (a) sprains, 9-10; (b) falls, 8-9; (c) improper handling of materials and equipment, 7; (d) unsafe practices, 5; (e) other causes, 17. Loss per injury, $400; annual loss through injuries, $18,800; time lost per injury, 11 days; annual time lost through injuries, 517 days.

AMBULANCE

Frequency of hospitals which:



- PROVIDE AMBULANCE SERVICE
- OPERATE OWN AMBULANCE
- USE CITY OR PUBLICLY OWNED AMBULANCES
- USE PRIVATE NONHOSPITAL AMBULANCES



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Nine Reasons for a Full-Time Pharmacist

In addition to his basic purpose of providing safe, economical pharmaceutical service to patients, the pharmacist can render valuable assistance to such departments as nursing, dietary, housekeeping

GROVER C. BOWLES Jr.

PHARMACY is generally recognized as a full department on the hospital organizational chart, at the operating level. The pharmacist in charge has full department head status and is an important member of the medical care team. He should be responsible to the proper administrative authority in the hospital for developing, supervising and coordinating all activities of the pharmacists. A well organized hospital pharmacy can be broken down into specific functions, each of which has a definite objective within the over-all purpose of the department.

IMPORTANT TO PATIENT COMFORT

First would be pharmaceutical service to patients. Providing good, safe, economical pharmaceutical service to patients is the most important function of any pharmacy department. Included in this would be the development and maintenance of standards, purchasing, compounding, manufacturing, storage and dispensing of all drugs used in patient care. If outpatient facilities are operated in the hospital, then adequate outpatient pharmaceutical facilities should be provided. The pharmaceutical needs of the patient frequently include catheters, crutches, elastic bandages and a variety of nondrug items. All are equally important to patient care and patient comfort and should be taken care of without hesitation.

Second would be drug control. The pharmacist is usually a member of the pharmacy or therapeutics committee and should contribute to establishment of a sound therapeutic program for the hospital. Professional policy relating to drugs should emanate from this committee.

Responsibility for the control of narcotic drugs and alcohol within the hospital is also assigned to the hospital pharmacist. This includes the purchase, storage, dispensing and proper accounting for narcotics, alcohol and other drugs coming under state and federal control. The hospital administrator should be familiar with the controls established. It is important that in dealing with alcohol and narcotics, all shortages be detected and reconciled regardless of where they occur—even if they occur in the pharmacy. Most hospitals that have a pharmacy department have adequate controls set up for narcotics and alcohol. If there is a weak link, it is usually in the pharmacy, because the pharmacist gets behind with other things and it's so easy to let records get behind.

If I were a hospital administrator I would spot-check — occasionally, at least. I would interest myself in what type of control was being maintained. In the last four or five years I've known of two pharmacist addicts who were working in hospitals. The better controls you have, the more likely you are to detect addicts.

HAS USEFUL INFORMATION

Third in this list of functions would be information and consulting services. The pharmacy should be the department in the hospital from which physicians, nurses and various other staff members can obtain factual information about the properties, dosage, administration, precautions and proper identification of drugs used in patient care. Information regarding poisoning from widely used household agents and agricultural agents should be available in the pharmacy, and information regarding treatment and antidotes should also be available. In addition to the standard textbooks, the pharmacy should subscribe to the professional journals, so that the pharmacists may be up to date on information that is too new to be recorded in textbooks.

Closely allied with the information and consulting service is the teaching responsibility of the hospital pharmacist. This may include formal or informal lectures to the student nurses and maybe to the intern and resident staffs. It has been my experience that the most effective approach is informal. You can get further with the doctor over a cup of coffee than by

Mr. Bowles is chief pharmacist of Baptist Memorial Hospital, Memphis, Tenn.

This article has been condensed and adapted by the author from a paper presented at the Mississippi Pharmacy Forum for Hospital Administrators sponsored by the Mississippi Hospital Association, Jackson, Miss., May 1956. This is the first section of Mr. Bowles' paper; the concluding section will appear in February.

contacting him in the hall or when he is in the pharmacy.

Another function of the pharmacy is service to special departments, such as dietary, clinical laboratory, maintenance and laundry. I don't believe there is a single department in the hospital that the pharmacy can't supply something for or help in some way. For the dietary department there are sodium baking powder or low sodium baking powder, dietary supplements, a variety of flavoring materials —the sort of thing which can be provided by the pharmacy. Of course, we all know it's not legal to use tax-free alcohol in dietary flavors! Then in the laundry there are bleaches and stain removers. Certain types of stain removers are used in maintenance. We found that camphorated oil is a good material for painters to rub on their hands after they have had them in the paint remover for too long a time.

Altogether, there are many ways in which the pharmacy can be of service to the hospital other than by filling prescriptions for actual drug needs of patients.

Proper inventory control is still another function that saves a lot of money for the hospital and provides better service. Every pharmacy should have a purchase card control setup of some type. There should be a card for each item that is purchased, with space to record when the purchase is made, the shipping date, and when it is received. When this system has been in operation for about a year you can determine usage for a year, and you may want to buy in larger or smaller quantities. You may find that the hospital isn't buying from the best sources.

The pharmacist in charge also assumes responsibility for having ample, yet not excessive, stocks of all drugs, including those needed in emergencies. Hospital pharmacists should never forget that they are paid to protect the hospital and not let their personal friendships enter into purchasing arrangements.

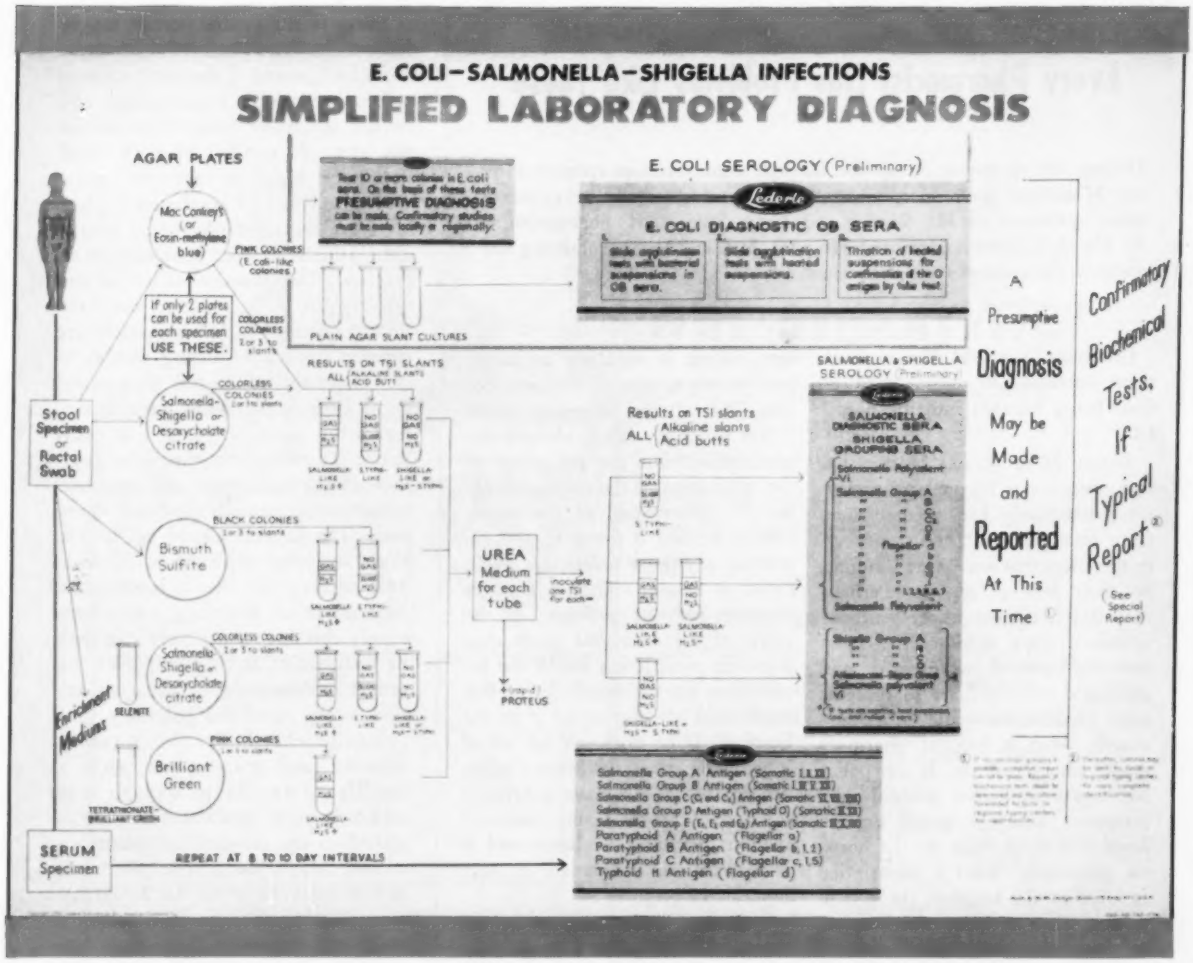
Good organization always provides two-way communication. The pharmacist in charge should originate such reports as are required to keep the hospital administration informed about the operation of the pharmacy. In recent years, we have seen expensive drugs marketed that could really upset the hospital budget. For example, the pharmacist is in a position to see something developing like penicillin, cortisone or, later, metacortin — and have reason to believe the new drug is going to be used in large quantities. I think it is good to mention that kind of development to the administrator. Most administrators wouldn't want a lengthy report to thumb through and read, but it is wise to submit a brief report or mention this kind of development informally to the administrator to keep him up to date on the department. I have heard pharmacists say, "We have the best administration department in the world — they stay completely away from us; they never bother us and we never bother them!" I question whether a man is doing a good job if he doesn't "bother" the boss occasionally, at least to keep him informed of what is taking place.

The pharmacist should also assist in establishing and carrying out research on hospital and pharmaceutical problems. The type of research I am referring to is not necessarily carried out in expensively equipped laboratories, but is the common-sense variety—an attempt to find a better, more efficient way of doing work.

It is a common misconception that a small hospital cannot afford the full-time services of a pharmacist. This has been disproved many times. I don't believe any hospital with 50 beds or more can afford not to have a pharmacy. In other words, the small hospital will find it less expensive to have a pharmacist than it would be for nurses to take care of drug needs or to depend on outside sources to provide the pharmaceutical needs to the hospital. Money saved through intelligent purchasing and inventory control alone will pay the pharmacist's salary. Many small hospitals find it advantageous to employ a full-time pharmacist and then assign other duties to him. First of all, however, the pharmacist in the small hospital must be a good pharmacist. Once all the needed pharmaceutical services have been accomplished, if the pharmacist has additional time, other duties may be assigned to him.

In the small hospital, the pharmacist cannot be a specialist. He must be adaptable, and, most important, he must understand that there is nothing wrong with taking on other duties than pure pharmacy.

Among the nonpharmaceutical duties that might be assigned to the pharmacist, the first one that comes



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Every Pharmacist Has Problems Like These

During the pharmacy forum for hospital administrators sponsored by the Mississippi State Hospital Association, members of the audience asked questions of Mr. Bowles and Sister Mary Carl, pharmacist at St. Dominic-Jackson Memorial Hospital, Jackson, Miss. Following are some of the questions and their answers:

Question: I would like to hear some discussion of outside medications being brought into the hospital.

SISTER MARY CARL: When we first opened our hospital pharmacy, we immediately had repercussions from retail pharmacists in our city to the effect that we were trampling on their area of service. Perhaps they did not quite understand our situation. As a result of the repercussions, however, we drew up and published some policies so that the retail pharmacists would understand exactly what a hospital pharmacy is and what it will do. In our policy we have a regulation that only prescriptions which originate in the hospital will be filled by the hospital pharmacy. After a prescription is filled in the hospital, the patient is free, after he leaves the hospital, to have the refill taken care of wherever he likes. If he wishes to have a refill taken care of at his own local pharmacy, all that is required is that the pharmacist call us for the prescription number and content. We readily give all information on prescriptions to qualified pharmacists. If the patient wishes to come back to the hospital for a refill we feel justified in going ahead and refilling the prescription ourselves. We are located far out from the downtown area, and we do not get many of these orders for refills, which is perfectly all right with us.

Question: Do you permit patients to bring medications into the hospital?

SISTER MARY CARL: That is a problem. Sometimes it is a problem for the patient, and therefore we give it consideration. If the patient does bring in a quantity of medication and we know that it is expensive, and the patient has been taking it regularly at home, then we try to identify the prescription. We call the pharmacy where it was originally filled, identify the prescription, and put the name of the medication on the original bottle for the information of the nurse. No medication is given to any patient by any nurse unless that medication is known. That is a safety measure for our patients. If the name of the identified medication is on the prescription bottle, the patient may use the remainder of that medication as long as he is in the hospital. If he does not use all of it before he leaves, the name is taken off the bottle—we have a type of tape that can be easily removed without defacing the label—and it is returned to the patient to take home if he requires it.

Question: How does a lay administrator tell when a drug is approved or is in the U.S.P., N.F., or N.N.R.?

MR. BOWLES: It is fairly difficult for a person who does not understand the generic terminology of drugs. Many times the pharmaceutical firm can tell you what it is. Most new drugs now are marketed so soon after they have proved to be safe that they are not yet accepted by the N.N.R. and certainly not in the U.S.P. or N.F. The National Formulary and the United States Pharmacopeia are legal standards for drugs and are revised every five years, with frequent supplements distributed during the intervals. It takes considerable time for a drug to be approved. The American Medical Association publishes the New and Nonofficial Remedies, and they have recently changed a lot of their policies on approval and listing of drugs. So it is difficult; the best procedure could be to call

(*Continued on Page* 108)

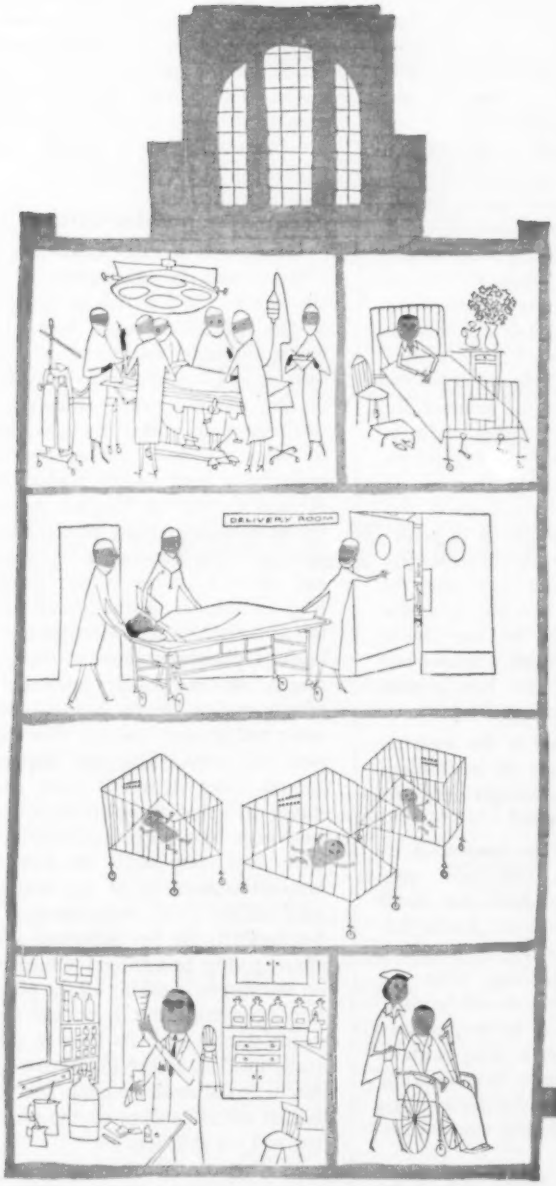
to mind is the central sterile supply department. The pharmacist by virtue of his background in the basic sciences such as chemistry, microbiology and physics is ideally suited to supervise this area. A number of both small and large hospitals now are going over to this type of combination pharmacy and central sterile supply department, which has been demonstrated as practical. One practical aspect is that delivery has to be made to and from both departments. Where people are coming from the nursing station to the pharmacy or central supply and going back to the floors, both departments can often be covered as easily as one. There are also some advantages in reducing equipment and personnel requirements through combined operation. The Clinical Center of the National Institutes of Health at Bethesda, Md., for example, has a combination department of pharmacy and central supply that is operated very efficiently by pharmacists and lay employes. No nurses are assigned to the combination supply room and pharmacy.

Equipment that requires careful cleaning and maintenance such as sterilizing apparatus, oxygen tents and orthopedic appliances may be assigned to the combination pharmacy-central supply unit. The pharmacist is not expected to do the actual routine cleaning, but he is expected to train and supervise the people who are going to work with such equipment and maintain it. It is also up to him to see that such equipment is available at all times.

Another function that can be assigned to the pharmacist, and I think it works particularly well for small hospitals, is purchasing for the entire hospital. The pharmacist is familiar with good business practices and experienced in preparing detailed specifications for drugs and chemicals. The pharmacist is also experienced in interviewing manufacturers' representatives. A great many pharmacists purchase surgical supply instruments, catheters, crutches and other surgical supplies.

Supervision of the hospital storeroom may also be assigned to the pharmacist. Here again it is understood that the pharmacist would not carry out all the routine work involved in receiving and dispensing items of stock. Instead, he would supervise the operation and see that adequate controls are set up to perform efficiently.

A few years ago we heard quite a lot about the pharmacist doubling as



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Pharmacy Questions and Answers

(*Continued From Page* 106)

a pharmacist in the community or a near-by hospital. If I were not a pharmacist I would not attempt to determine whether a drug was approved or not approved. Sometimes pharmacists have troubles of their own.

Question: How do you control the use of investigative drugs in hospitals?

MR. BOWLES: Before the war, experimental drugs were used for the most part in the university teaching centers, but now clinical studies are going on in almost every hospital in the country, and control becomes a problem. The experimental drug should be sent to the pharmacy first, with all the information the investigator has about it—the dosage, the contra-indications, the antidotes, and that type of thing. The drug should be prescribed only by the investigator who signed the Food and Drug Administration forms, or by someone authorized by him. Thus you have a legal record of how the drug is used, and you have somebody other than the investigator who knows what is taking place and knows something about the drug. The thing that often happens is that when you get into difficulty the investigator himself is out of town at a meeting, or has gone home and you can't locate him, so somebody else in the hospital should know about the drug, and it should be the pharmacy department. The pharmacy and therapeutics committee should have a policy requiring that all investigational drugs being used in the hospital be listed with them and that they be labeled properly through the pharmacy department.

From a practical standpoint, it just doesn't work that way very often. The investigator thinks his toes are being stepped on, or that his prerogatives are being limited, or that you're hampering research —and so you find drugs on the floors that you didn't know were in use. That's another reason for the periodic inspection of drug storage on patient floors; you may find investigational drugs there. But the real answer is to have these drugs dispensed through the pharmacy department and to put pressure on the investigator to supply the information before the drug can be used.

Question: Is the hospital liable for accidents arising from the use of experimental drugs?

MR. BOWLES: If a plaintiff can show negligence, you would be. You would be in a much stronger position if the drug had been dispensed through the pharmacy on a prescription and information was on file in the pharmacy about overdosage and antidotes. But it's the doctor's responsibility, and the business of dispensing drugs out of the doctor's desk drawer—keeping the supply there and giving some to the interns to use—is not good patient care. I've spent six years in a university teaching hospital, and it's like pulling eye-teeth to get an investigator to part with his investigational drug. He may take the whole container and put it on the nursing floor and let any doctor take out of it for his patients, and until somebody gets into trouble you may never know about it!

Question: What is the legal responsibility in case of medications that have been brought into the hospital by patients?

MR. BOWLES: The hospital is responsible unless you have gone through the procedure that Sister Mary Carl has outlined. You're definitely negligent if you do not check through to determine what the drug is and how it should be used. Any time a nurse or hospital employe administers a drug without knowing what he is administering, he is negligent, and I believe that is the way the courts would interpret it.

Question: Wouldn't it be safer not to permit any drugs to be brought in by patients?

MR. BOWLES: It would be convenient to say that you would not permit any outside medication to be brought in, but you would get into some ridiculous situations—for instance, with the diabetic who brings in his insulin, or the patient who has been taking thyroid for

(*Continued on Page* 110)

a laboratory technician or x-ray technician, but this combination has not grown very rapidly—primarily I think because pharmaceutical demands seem to occur at the same time that laboratory work needs to be done or x-rays need to be taken. For this reason, I doubt whether it is a logical combination for the average hospital pharmacist. Of course, some additional training is also needed, but generally the pharmacist has a suitable background for those two jobs.

MAKE GOOD ADMINISTRATORS

In addition to the doctor and the administrator, the pharmacist is usually one of the few college graduates on the staff of the small hospital. It would thus seem that his talents might be used to good advantage as assistant to the administrator, particularly in small hospitals where the administrator does not have an assistant and must be a jack of all trades. The Medical College of Virginia has recognized the desirability of a combination of administration and pharmacy and offers a course at the graduate level in hospital pharmacy and hospital administration. Unfortunately for hospital pharmacy, most of the pharmacists become vitally interested in administration, leave hospital pharmacy and go into hospital administration full time. That has happened several times in recent years, and I might add that the pharmacists who have gone into hospital administration have done very well. At least one hospital pharmacist of my acquaintance handles public relations work for his hospital. He has published a brochure giving background information on the hospital—taking all the pictures himself, writing the script, and supervising publication. As I see it, there's really no limit to the rôle of the pharmacist in the small hospital. The possibilities are dependent on the pharmacist and his abilities.

One of the contributing factors to the expanded rôle that pharmacists are playing in hospitals today has resulted from the development of the new minimum standards for hospital pharmacies. The minimum standards are a statement of what constitutes good pharmacy practice; they are not in any sense an attempt to put all hospitals into a single mold. It is recognized that each hospital presents different needs for pharmacy service, dependent on type, size and location. The standards cover organization, policies, per-

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sonnel, facilities, responsibilities and pharmacy-therapeutic committee.

The organization section merely states that there will be a properly organized pharmacy department under the direction of a competent, legally qualified pharmacist. The section on policies states that administrative and professional policies may of necessity overlap. Certainly definite policies should be developed by the pharmacist in cooperation with the administrator regarding filling outside prescriptions, dispensing drugs, personnel, outgoing medications, and a variety of other problems which are bound to occur. Professional policies should be referred to the pharmacy-therapeutics committee.

SPELLS OUT QUALIFICATIONS

The personnel section is an attempt to spell out the qualifications of the pharmacist. It also suggests that additional personnel may be needed to supply pharmaceutical service of the highest order. If lay employes are used, it is expected that they will be confined to routine activities and that they will be properly supervised by the pharmacist in charge.

The physical facilities section sets forth the facilities required to provide good pharmacy service. Proper space is required; it should be well lighted and well ventilated, with secure storage space provided for alcohol and narcotics. The office space is usually limited to a desk and filing cabinet, but the pharmacist in charge should have some space to do patient work, prepare reports and purchase orders, and maintain necessary files. If at all possible, I think it is fine for him to have an office of some type that separates him from the rest of the pharmacy.

The library is also an essential part of any pharmacy, but the mere ownership of books is not sufficient; the pharmacist should be familiar with the texts and use them as frequently as indicated. He should also read journals, scan the manufacturers' lists and keep up to date.

The standards on responsibilities point out that the pharmacist in charge should be responsible for the preparation and sterilization of medications if these are manufactured in the hospital. This is something I feel very strongly about. I believe the trend is toward the pharmacist preparing intravenous solutions if they are prepared in the hospital. For many years, this

Pharmacy Questions and Answers

(*Continued From Page* 108)

10 years, or the cardiac who takes digitalis, or the person who has just had a prescription filled for acromycin or aureomycin or one of the expensive antibiotic drugs and has a large financial investment in it and the pharmacist can identify it very easily. Then to say that the patient can't use it is unfair.

Question: How do you satisfy the patient that he is getting the same drug his doctor has prescribed outside the hospital, when you use a different brand?

MR. BOWLES: It is up to the nursing staff or the doctor to prepare the patient and let him know there may be different colored capsules. Sometimes you get into a real problem because a patient may be adjusted to a particular brand of thyroid or digitalis and you may give him another brand to which he doesn't respond as he does to

his own particular brand. It's up to the doctor to determine whether he wants to continue with the same brand or use what you have.

There is one other aspect to the problem of bringing medications in which is difficult to control—that is, the expensive hormone preparations which the doctor has in his office and carries in his bag. Often he goes into the patient's room and says, "Well, now, I'll save you some money! I'll give you this and it won't be on your hospital bill!" He bills the patient for the drug himself, and there is no record of it on the chart or anywhere else. The doctor knows the patient is getting it, which is all right; the patient knows he is getting it, which is all right, except that the doctor is taking over part of the hospital's function here. That is hard to control. But if you instruct nurses not to give any medication other than those supplied by the pharmacy, and enforce this regulation, it will solve a lot of the problems.

was done routinely in central supply departments, and still is in some hospitals.

I don't mean to imply by this that central supply cannot do a good job. I've worked in hospitals where central supply was doing an excellent job of preparing solutions, but I think those are fewer in number than the hospitals in which the pharmacy supplies and manufactures the solutions. The pharmacist is ideally prepared, educationally and from a commonsense point of view, for preparing solutions. He is accustomed to weights and measures. If an inaccuracy shows up in a formula, there is more chance for a person who is used to weighing salts to realize that something is wrong. In one hospital recently, to illustrate this point, procaine was weighed out as dry salt and sent to the operating room, where it was diluted with distilled water, bottled and autoclaved. The surgeons kept complaining that they weren't getting the full effect of the procaine, so the pharmacist was asked where he was buying the procaine, whether he had changed brands, and so on.

Finally, investigation showed that the operating room staff was autoclaving the procaine solution in a soft glass bottle. There was enough alkalinity in the bottle to neutralize the procaine hydrochloride, some of which was destroyed during the autoclaving. Hard glass bottles were substituted and a minute quantity of hydrochloric acid was added. This is the type of thing the pharmacist is trained to do. Thus it seems if solutions are going to be prepared at the hospital, the logical place is in the pharmacy.

CALLED "BULK COMPOUNDING"

As for the "manufacture" of pharmaceuticals, we don't want to call it manufacturing. We call it "volume compounding" or "bulk compounding." If a certain ointment is prescribed with great regularity, for example, it might first be made up in 1 pound units; then if it is going to be used a great deal, you might make up 5 pounds. It is one of the responsibilities of the pharmacist to conserve his own time—to do this bulk compounding and at the same time do some prepackaging. Dispensing of drugs, chemicals and pharmaceutical preparations is certainly a responsibility of the pharmacy department. I have a feeling that should include all the therapeutic agents that

are used in the hospital, including such things as x-ray diagnostic drugs, skin test media, vaccines and other agents.

The filling and labeling of all drug containers issued in all cases where medication is to be administered is important also. If the pharmacist does not assume the responsibility for labeling, then the nurses do, and they often use adhesive tape and wax pencils and may scratch out a label and write over it. The patient in the hospital actually deserves a little safer treatment. The pharmacist must be responsible for leaving necessary instructions on all pharmaceutical supplies on all services. He should actually go to the nurse's station and inspect the drug cupboard, with the representative of the nursing department, and check for drugs that are outdated or deteriorated or improperly labeled. In the refrigerator, he must check for biologicals which may be outdated, and this inspection should go on to the operating room, the delivery room, and the emergency room. I don't know of any way other than by an inspection program that you can possibly keep people on the patient floors and in the operating room and emergency room from accumulating odds and ends. This inspection should be done every month. I know from experience it is difficult for the pharmacist and the nurses in the department to find time to get on the floors and do a good job; however, if you do it every three or four months, that's certainly better than not doing it at all.

Finally, the pharmacist should be responsible, in cooperation with the accounting department, for the establishment and maintenance of a system of records and bookkeeping in accordance with the policies of the hospital. This includes charges to patients for drugs and pharmaceutical supplies and maintaining adequate control of requisitioning and dispensing all drugs and pharmaceutical supplies to the hospital departments.

The final portion of the minimum standards deals with the requirements for the therapeutics committee. This standard requires that there shall be a pharmacy and therapeutics committee and that the committee must meet at least two times a year, preferably oftener. It states that the hospital pharmacist should be a member of the committee and should serve as its secretary. He shall keep a transcript of the proceedings and forward a copy of the proceedings to the proper governing authority of the hospital. The purpose of this committee is that of developing a formulary of accepted drugs for use in the hospital. The committee also serves as an advisory group to the hospital pharmacy in matters pertaining to the choice of drugs to be stocked; it provides clinical data concerning drugs requested for use in the hospital, adds and deletes from the list of accepted drugs, and prevents unnecessary duplication of stocks of the same basic drugs.

Of necessity, the implementation of the minimum standards for pharmacies in hospitals must be a long-term educational project. This has been the approach of the American Society of Hospital Pharmacists for 10 years. Fortunately, the American Pharmaceutical Association, through its Division of Hospital Pharmacy, has recently received a grant of $36,000 from the Public Health Service to finance a survey to determine what constitutes adequate pharmacy service in hospitals. The survey will help us determine whether these minimum standards are adequate and practical or whether the standards should be revised.

Conducted by Mary P. Huddleson

Turkey Is Simply Stuffed With Protein

No longer either a seasonal or a luxury item, the turkey has become a nutritional necessity, according to studies made at Cornell University

TURKEY, once strictly a seasonal treat, is now being acclaimed by dietitians and nutritionists as a "must" for all high protein, low fat diets.

Recent tests completed at Cornell University establish turkey as highest in protein over all other poultry and red meats. Turkey also was found to be extremely low in fat content, and it rated top on the list of meats in riboflavin and niacin.

Dr. M. L. Scott of Cornell University, who directed the studies on comparative protein, fat and vitamin content of turkeys and other meats, has this to say about the need for protein in the human diet:

"Our present high standard of living goes hand in hand with the increased per capita consumption of lean, high quality animal proteins—and turkey heads the list of lean meats in high protein and low fat content."

Figures resulting from the Cornell studies reveal roast turkey white meat contains a 35 per cent high in protein and an 8.3 per cent low in fat. Slightly lower in protein composition, but still high above other meats, was turkey dark meat with 30.8 per cent protein and 11.2 per cent fat content. In comparison, roast beef ranged in the low twenties with protein ratings of 21 per cent for rump roast, 22 per cent for hamburger, and a high of 27 for round steak. Fat content in beef cuts was two and three times higher than that of turkey.

Pork and lamb both averaged between 23 per cent and 24 per cent in protein content, with fat percentage running in the thirties. Veal was considerably higher in protein, with 28 per cent. Only chicken roasters at 18 weeks' maturity approached turkey's high with protein ratings of 31.5 per cent for breast meat and 25.4 per cent for leg meat.

In spite of the fact that turkey meat contains sufficient fat for tenderness and palatability, the caloric content was not found to be high. In terms of 100 gms. of cooked meat, turkey was comparable to veal and round steak. It contained more calories than young chicken roasters but was much lower in caloric content than *all* other meats.

Many nutritionists and dietitians have long recognized turkey as a high protein meat. The Cornell tests substantiate this and support turkey's place in high protein, low fat diets.

During recent years the per capita consumption of turkey has risen faster

Patient looks interested as a nurse presents a turkey dinner, which, studies indicate, will provide lots of proteins and not many calories.

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CORNELL TABLE OF MEATS

Nutrient Composition of Cooked Turkey Meats in Relation to Other Cooked, Boneless Cuts of Meat

Meat	Protein %	Food Energy Cal/100 gm.	Calorie-Protein Ratio Cal/1% Protein	Fat	Moisture	Ash	Riboflavin Mg/100 gm.	Niacin
Turkey, roasted and boned								
Breast (white meat)								
Male	33.5	194	5.8	6.7	59	1.1	.42	9.4
Female	35.0	215	6.1	8.3	56	1.1	.38	11.6
Leg (dark meat)								
Male	30.8	224	7.3	11.2	57	1.0	.94	4.1
Female	30.3	230	7.6	12.1	56	1.0	.86	4.1
Skin	17.7	375	21.2	33.8	45	1.0	...	...
Edible viscera								
Male	23.5	200	8.5	14.0	61	1.6	3.15	...
Female	17.8	254	14.3	20.3	61	1.2	2.28	...
Smoked Turkey, boned								
Breast	31.0	207	6.7	9.2	57	2.8	.23	...
Leg	30.2	221	7.3	11.1	56	2.8	.47	...
Chicken, roasted and boned								
Breast	31.5	138	4.4	1.3	66	1.0	.30	10.5
Leg	25.4	168	6.6	7.3	67	0.9	.60	5.6
Veal, cooked and boned								
Cutlet	28.0	219	7.8	11.0	60	1.4	.28	6.1
Shoulder roast	28.0	228	8.1	12.0	59	1.4	.31	7.9
Beef Cuts, cooked and boned								
Round steak	27.0	233	8.6	13.0	59	1.3	.22	5.5
Chuck roast	26.0	309	11.9	22.0	51	0.7	.20	4.1
Rib roast	24.0	319	13.3	24.0	51	1.2	.18	4.3
Porterhouse steak	23.0	342	14.9	27.0	49	1.1	.18	4.7
Rump roast	21.0	378	18.0	32.0	46	0.5	.15	3.1
Hamburger	22.0	364	16.5	30.0	47	1.1	.19	4.8
Pork, fresh, cooked and boned								
Ham	24.0	400	16.7	33.0	42	1.2	.24	4.7
Loin chops	23.0	333	14.5	26.0	50	1.2	.24	5.0
Pork, cured, smoked and boned								
Ham	23.0	397	17.3	33.0	39]	5.4	.21	4.2
Lamb, cooked and boned								
Rib chops	24.0	418	17.4	35.0	40	1.2	.26	5.6
Leg roast	24.0	274	11.4	19.0	56	1.1	.25	5.1
Shoulder roast	21.0	342	16.3	28.0	50	1.0	.22	4.6

than that of any other meat, in fact, 59 per cent above the 1945 national average. This has been largely a result of increased consumption by hospitals and other institutional food servers who have scheduled turkey on their menus the year around.

A recent survey covering four major hospitals in different parts of the country showed turkey ranked first in popularity with patients in two of the hospitals and second in the other two. Three of the four hospitals ranked turkey as the second or third most economical of meats, only slightly less economical than such meats as ground chuck of beef, baked beef hearts, and pork dishes.

These hospital studies indicated that the number of satisfactory portions obtainable from 100 pounds of turkey (uncooked, eviscerated weight) ranged from 100 to 255, depending upon the size of the portion served. The portion cost for turkey dishes ranged from as low as 12.5 cents for a 2 ounce portion of turkey à la king or a hot turkey sandwich to 28 cents for a roast turkey dinner dish. Comparable costs of similar servings of other poultry and meat dishes ranged from a low of 13.9 cents to a high of 45 cents for the same period.

In most hospitals turkey meat is permissible for all patients not on special or strict liquid diets, the white meat of turkey being allowed on soft or semi-solid diets. Since the purpose of these special diets is to provide easily digested foods of high nutritive value, turkey meat with its high protein, low fat content, plus its bland flavor and adaptability to different methods of cooking, is a favorite.

Turkey by nature has always been a high protein meat. In recent years, however, America's turkey industry has placed a stress on scientific improvement of its product. The industry's chief concern has been development of a smooth grained, meatier bird. The result of these research programs is the present block-like, meaty turkey with 50 per cent more meat in proportion to bone weight. Because of this evolution it was necessary to reevaluate turkey meat in terms of protein, moisture, ash and physiological fuel value. These accurate data are now made available through the Cornell protein studies.

As to the importance of protein in the diet, Dr. Herbert Pollack, secretary of the committee on therapeutic Nutrition, National Research Council, Mount Sinai Hospital, New York, recently declared:

"Proteins play a very important part in human nutrition as they do in animal nutrition. Proteins in the body control osmotic pressure which influences the water balance or fluid content of the circulating blood. If inadequate proteins are consumed, the circulating proteins decrease and the animal or human being develops what is known as starvation edema, or a form of dropsy. . . . Proteins are the functional unit for the immune responses of the body. The body's ability to fight disease, the body's ability to

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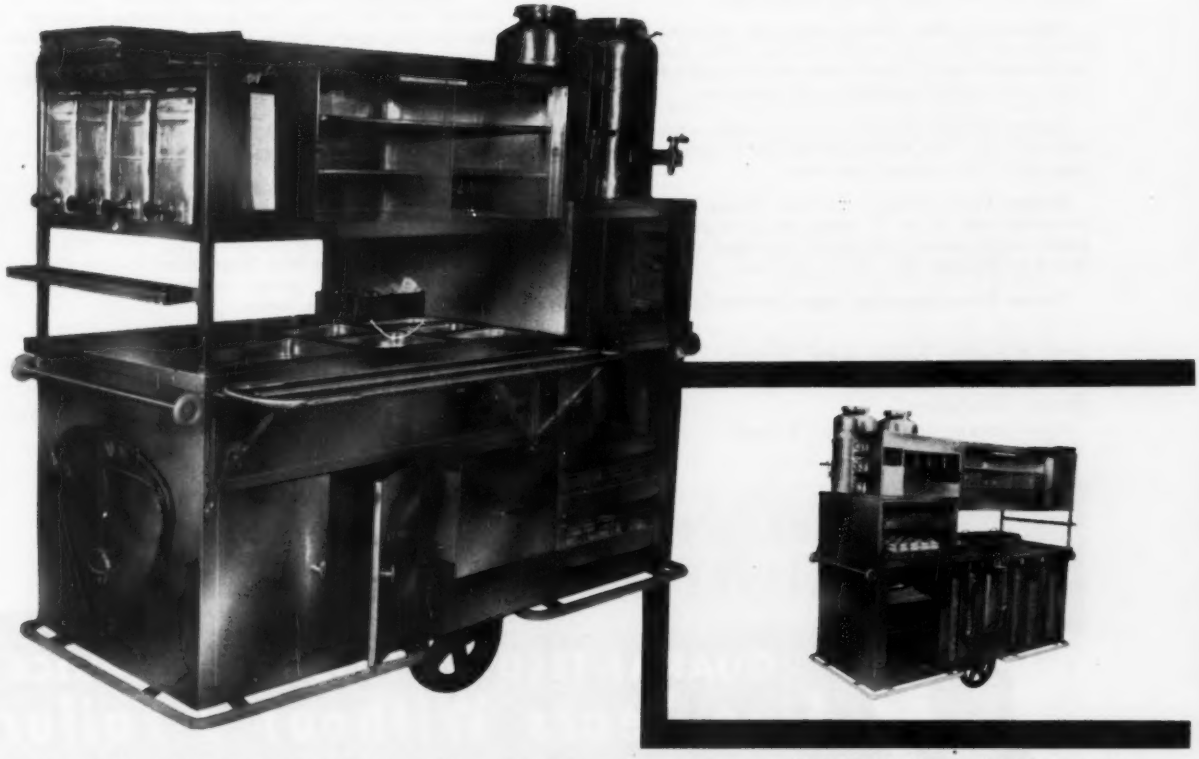

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save... **time!** Patient serving time reduced by 50%. Paper work is cut to a minimum by eliminating menu orders. The communication system is also relieved.

save... **money!** There's no waste in food returns! A report from one hospital reveals that the Mobilteria is saving them $9,464.00 per year! This means that the low unit cost of the Mobilteria is more than paid for through savings, in the first six months of operation.

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TEN-WAY CREAMED TURKEY

3 Tbsp. butter or margarine
4 Tbsp. flour
1 cup turkey broth
1 cup milk
½ tsp. salt
½ tsp. paprika
⅛ tsp. pepper
1 tsp. finely grated onion
1½ cup diced cooked turkey
2 Tbsp. Sherry wine, optional

Procedure: Melt butter, add flour and stir over low heat until blended. Add cold broth and milk all at once. Cook, stirring constantly, until uniformly thickened. Then set over hot water. Add the seasonings and turkey and heat thoroughly. Add more seasoning if desired. Blend in wine just before serving. Serve over biscuits, toast, plain or fried noodles or rice. Makes six servings.

Note: If creamed mixture is thicker than desired, thin with hot milk or water. All recipes, six servings.

Turkey à la King: Cook ¼ cup finely chopped green pepper in the butter for a few minutes before adding flour. Proceed as for Creamed Turkey. Add 1 chopped pimiento and a small can (4 oz.) well drained mushrooms with seasoning.

Turkey Terrapin: Prepare creamed turkey reducing the turkey meat to 1 cup. Just before serving add 4 chopped hard cooked eggs and ¼ cup chopped ripe olives.

Turkey Curry: Prepare Creamed Turkey. To the foregoing seasonings add ½ to 1½ teaspoons curry powder and ½ cup grated fresh coconut. If canned shredded coconut is used, it should be chopped finer. Serve over rice.

Turkey Curry Hawaiian Style: Prepare Turkey Curry. Serve in coconut shells which have been sawed in half crosswise to make 6 serving shells. Remove some of the coconut meat and use in the preparation of the currry. Prepare 6 cups of rice. Grease inside of shells. Line shells with a half-inch layer of rice, reserving enough to cover top. Pour in Turkey Curry. Top with rice. Bake in a hot oven (400° F.) about 20 minutes.

Creamed Turkey and Pineapple: Prepare Creamed Turkey. Just before serving add ½ cup well drained canned shredded pineapple or ½ cup finely diced fresh pineapple and ¼ cup slivered almonds. This may be served in hollowed out fresh pineapple shells cut lengthwise with stem still on. Top with Parmesan cheese and place in broiler as far as possible from heat. Broil until top is lightly browned.

Turkey Rarebit Style: Prepare Creamed Turkey, reducing the turkey meat to 1 cup. Add a well drained 4 oz. can of mushrooms. Just before serving stir in ½ cup grated Cheddar cheese and 1 chopped canned pimiento. Serve over toast or rusks. For variation top each serving with a slice of pineapple heated in its own juice or sautéed in a small amount of butter.

Creamed Turkey and Ham: Prepare Creamed Turkey substituting ¾ cup diced cooked ham for half of the turkey (¾ cup).

Creamed Turkey and Shrimp: Prepare Creamed Turkey substituting ¾ cup cooked or canned shrimp for half of the turkey (¾ cup).

Creamed Turkey With Vegetables: Prepare Creamed Turkey substituting ½ cup cooked vegetables (peas, corn or mixed vegetables) for ½ cup turkey.

develop immune bodies in the circulating blood are dependent on adequate protein metabolism."

The information in the "Cornell Table of Meats" will be especially valuable to the dietitian and nutritionist who plan and advise diets. It further emphasizes the growing recognition of turkey as a high protein meat for everyday serving in America's hospitals, where protein is symbolic of fine quality health foods.

FOOD FOR THOUGHT

Vitamin C Study

A significant reminder of the need for adequate vitamin C in daily diets is given in a recent research report from the New Mexico Experiment Station. Public health workers in that state have long been concerned because many school children have spongy, sore, bleeding gums which show up especially in winter, become worse toward spring, and usually improve somewhat in summer. The condition is sometimes found in young children but is much more common among teen-agers and becomes progressively severe with age. Frequently reddened eyes also were reported.

A three-year survey of diets and nutritional condition of a large number of children made by public health and experiment station workers showed that many diets were low in fruits and vegetables, particularly the citrus fruits and tomatoes which are especially rich in vitamin C. The shortage of vitamin C foods was reflected in low levels of vitamin C in the blood, often dangerously low for health. In the dry areas where many of the children lived it was not possible for families to have gardens or fruit trees. Prices of fresh fruits and vegetables on markets often were high enough so that families neglected these foods because they were not aware of the need for vitamin C every day for good health.

When children were given vitamin C daily for six weeks in a special study, the vitamin C levels of the blood became normal, and healing of the gums and other tissues followed gradually. The study showed that colds and other infections were a drain on the vitamin C in the blood.

The station report notes that the effect of lack of vitamin C in the diet is cumulative over a period of years. Children just entering school rarely show bleeding, sore, spongy gums but by adolescence the condition is severe and is even more severe in adults whose diet has always been low in vitamin C.

Too Little Milk

That many people are not getting enough milk to meet their nutritional needs has been said many times for many years by nutritionists. But Dr. Hazel Stiebeling of the U. S. Department of Agriculture points out that the first step in increasing milk consumption is to know which groups in our population are generally the low consumers of this important food.

As a group women probably consume the least milk—less than men, less than teen-agers, and less than younger children. Older women use less than younger women. Women over the age of 40 are likely to be cutting down on food either to control weight or because they are less active physically.

People in institutions, where food costs must be kept low, are likely to get too little milk. This may be particularly true of mental institutions, homes for the aged, and small nursing homes. Nonfat dry milk offers great possibilities for improving these diets as some of these institutions are beginning to learn.

In periods of body stress, Dr. Stiebeling says, generous quantities of milk are especially important. Yet many pregnant women whose nutritional needs can scarcely be met with less than a quart a day, even in a well chosen diet, consume relatively little milk.

Give them the ketchup they prefer at home—HEINZ

Little things are important to a patient. A single item of food can make or spoil a meal—especially when it's an item that makes other foods taste better. Such an item is Heinz Ketchup. The odds are that your patients use Heinz Ketchup at home. They're accustomed to the flavor. They like it. And on their hospital tray, it is one of the little touches that will make a big difference in the impression the patient carries away. Order Heinz Ketchup on your Heinz Man's next call.

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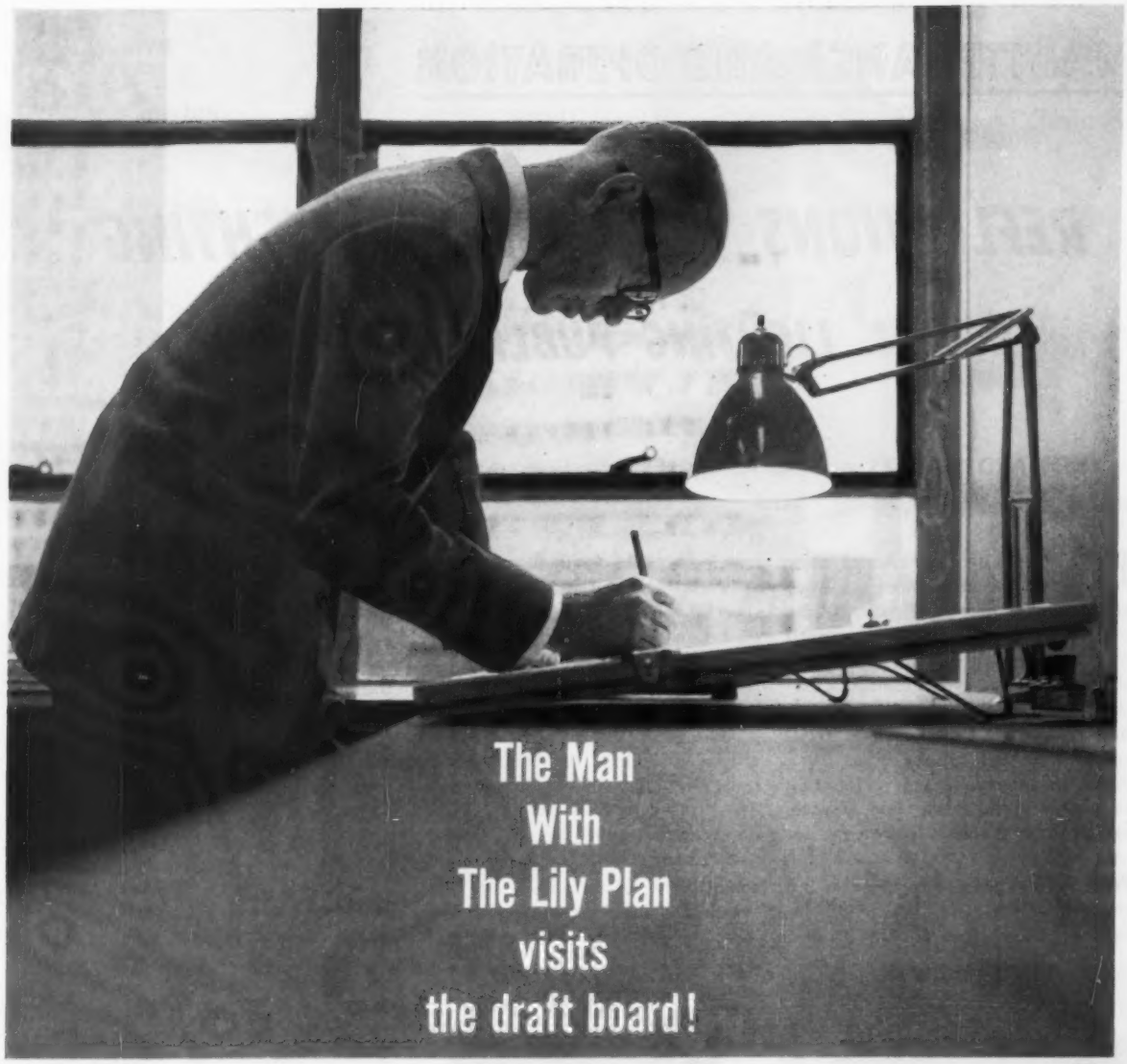
Menus for February 1957

Gayle T. Hodgson
Chief Dietitian
Allen Memorial Hospital
Waterloo, Iowa

1 Applesauce Soft Cooked Egg, Toast • Vegetarian Soup Creamed Tuna and Peas in Toast Cup Sliced Orange, Stuffed Prune Salad Gingerbread With Whipped Cream • Salmon Croquettes Creamed Potatoes Orange Beets Chopped Lettuce with 1000 Island Dressing Frozen Strawberries	**2** Grapefruit Half Egg, Crumb Coffee Cake • Potato Chowder Sliced Ham Sandwich Jellied Carrot and Pineapple Salad Peach Half Butterscotch Brownie • Roast Beef Franconia Potatoes Golden Kernel Corn Green Salad, Roquefort Dressing Apple Pie	**3** Tomato Juice Bacon, Raisin Toast • Chicken Broth Baked Beef with Noodles Broccoli, Cheese Sauce Apricot-Coconut Salad Vanilla Ice Cream • Pork Dainty Parsley Buttered Potatoes Frozen Squash Coleslaw with Sour Cream Dressing Fruit Cup	**4** Stewed Prunes Bacon, Toast • Cream of Pea Soup Barbecued Beef on Bun Potato Salad Celery, Radish, Pickle Chocolate Cake • Roast Leg of Veal Mashed Potatoes, Gravy Buttered Frozen Spinach Waldorf Salad Orange Sherbet	**5** Orange Juice Bacon, Toast • Split Pea Soup Braised Beef, Vegetables Baked Potato Pear and Grated Cheese Salad Lemon Fluff • Fried Liver Buttered Diced Potatoes Stewed Tomatoes Celery, Olive, Carrot Baked Apple Crisp	**6** Sliced Bananas Bacon, Orange Roll • Cream of Carrot Soup Meat Loaf, Chili Sauce Frozen Lima Beans Cabbage and Fruit Salad White Cake • Oven Baked Chicken Mashed Potatoes Frozen Peas, Mushrooms Rainbow Salad Butterscotch Sundae
7 Grapefruit Sections Poached Egg, Toast • Cream of Chicken Soup Corned Beef Hash French Cut Green Beans Carrot, Raisin Salad Fruit Gelatin • Breaded Veal Cutlet Baked Potatoes Asparagus Tips Peach and Cottage Cheese Salad Applesauce Cake	**8** Pineapple Juice Soft Cooked Egg, Toast • Tomato Bouillon Macaroni and Cheese Buttered Broccoli Hard Sesame Seed Roll Tossed Salad, Oil Dressing Green Gage Plums • Baked Halibut Escalloped Potatoes Parsley Buttered Carrots Pickled Pear Tapioca Cream	**9** Orange Juice Bacon, Yeast Coffee Cake • Scotch Broth Creamed Chicken, Biscuit Frozen Spinach, Lemon Wedge Coleslaw Apricots With Cream • Swiss Steak Mashed Potatoes, Gravy Buttered Cauliflower Jellied Lime and Fruit Salad Cottage Pudding With Chocolate Sauce	**10** Grape Juice Canadian Bacon, Toast • Chicken Noodle Soup Beef Patty, Bun Potato Chips Tomato Wedge, Pickle Slice Banana Pudding • Roast Leg of Lamb, Mint Jelly Creamed Potatoes Buttered Green Beans Mixed Vegetable Salad Bing Cherries Date Swirl	**11** Tangerine Scrambled Eggs, Muffins • Cream of Mushroom Soup Spaghetti with Meat Sauce Buttered Brussels Sprouts Chopped Lettuce, Celery Seed Dressing Peach Pie • Ham Slices Parsley Buttered Potatoes Frozen Green Peas Citrus Salad Strawberry Ice Cream	**12** Stewed Prunes Bacon, Toast • Cream of Celery Soup Meat Loaf, Horseradish Sauce Escalloped Corn Pineapple, Cream Cheese Salad Vanilla Blanc Mange with Cherry Sauce • Roast Beef Lyonnaise Potatoes Mashed Rutabaga Mixed Fruit Salad Butterscotch Pudding
13 Orange Juice Egg, Almond Roll • Pepperpot Soup Breaded Veal Cutlet au Gratin Potatoes Sliced Tomato Angel Food Cake • Roast Turkey Dressing Mashed Potatoes Buttered Frozen Asparagus Cranberry Relish Salad Pineapple Refrigerator Dessert	**14** Pineapple Juice Bacon, Toast • Egg Drop Soup Chow Mein, Noodles Chopped Lettuce, 1000 Island Dressing Apple Crisp • Baked Ham Candied Sweet Potatoes Buttered Mixed Vegetables Heart Shaped Jellied Salad Fudge Cake	**15** Orange Juice Creamed Eggs on Toast • Vegetarian Vegetable Soup Escalloped Tuna, Noodles Buttered Asparagus Stuffed Celery Apricot Cobbler • Baked White Fish Oven Browned Potato Broccoli, Cheese Sauce Peach Surprise Salad Whipped Gelatin	**16** Tangerine Canadian Bacon, Toast • Chicken Rice Soup Sautéed Liver Succotash Pickled Crab Apple Pineapple Upside Down Cake • Roast Leg of Veal Mashed Potatoes, Gravy Frozen Peas Green Salad, French Dressing Toffee Maple Cream	**17** Applesauce Soft Cooked Egg • Beef Broth Hot Roast Beef Sandwich Parsley Buttered Carrots Waldorf Salad Rainbow Sherbet • Pork Dainty Escalloped Potatoes Green Beans Pickled Whole Beet Salad Cherry Nut Cake	**18** Grapefruit Half Soft Cooked Egg, Toast • Cream of Asparagus Soup Barbecued Meat Balls Escalloped Potatoes Cabbage Salad Prune Whip • Breaded Beef Steak Mashed Potatoes Mexican Corn Pear, Cottage Cheese Salad Lemon Sponge Pudding
19 Rhubarb Bacon, Toast • Corn Chowder Shepherd's Pie With Whipped Potato Topping Jellied Pear in Lime Sweet Red Cherries • Cubed Steaks in Mushroom Sauce Baked Potatoes Shoestring Beets Chef's Salad Tapioca Cream	**20** Sliced Oranges Eggs, Cinnamon Roll • Cream of Tomato Soup Cottage Cheese and Fruit Plate Date Bread Chocolate Chiffon Pie • Baked Chicken Mashed Potatoes, Gravy Buttered Cauliflower Sliced Tomato Salad Butter Brickle Ice Cream	**21** Half Banana Poached Egg, Toast • Beef Barley Soup Creamed Dried Beef on Toast Points Frozen Peas Coleslaw Baked Peach Crunch • Roast Beef Franconia Potatoes Frozen Squash Rosy Pear Salad Spice Cake	**22** Prune Juice Egg, Apple Muffin • Clam Chowder Cheese Rarebit in Toast Cups Frozen Lima Beans Waldorf Salad Black Cherry Ice Cream • Salmon Loaf, Cream Sauce Baked Potato French Cut Green Beans Pickled Beets Fruit Gelatin with Whipped Cream	**23** Grapefruit Half Scrambled Egg • Tomato Bouillon Baked Chicken with Noodles Green Beans Chopped Lettuce, Russian Dressing Floating Island • Roast Leg of Lamb Parsley Buttered Potato Frozen Peas Stuffed Celery Cherry Pie	**24** Orange Juice Sausage Links, Toast • Cream of Corn Soup Porcupines Buttered Asparagus Mixed Fruit Salad Blueberry Crumb Cake • Swiss Steak Mashed Potatoes Stewed Tomatoes and Celery Green Salad Nectarines Sugar Cookie
25 Half Banana Bacon, Toast • Cream of Pea Soup Canadian Bacon Corn Custard Relishes Apple Sauce, Date Bar • Veal Steaks Baked Stuffed Potato Spinach, Chopped Egg Golden Glow Salad Baked Rice Pudding	**26** Orange Juice Bacon, Toast • Cream of Celery Soup Spanish Rice, Link Sausage Peas Pineapple, Cottage Cheese Salad Baked Custard • Baked Ham Mashed Sweet Potatoes Broccoli Ginger Ale Salad Peeled Apricots	**27** Peach Nectar Soft Cooked Egg, Bun • Vegetable Beef Soup Ham and Cheese Club Sandwich Potato Salad Sliced Tomato Strawberry Shortcake • Roast Turkey Celery Dressing Mashed Potatoes Mixed Vegetables Peach, Date Salad Pumpkin Pie	**28** Grapefruit Sections Poached Egg, Toast • Beef Broth Beef Pot Pie Baked Potato Lettuce Wedge, 1000 Island Dressing Orange Cream Sponge • Corned Beef Boiled Potatoes Carrots and Cabbage Jellied Bing Cherry Salad Butterscotch Squares		

Ready-to-eat or cooked cereals served on all breakfast menus.



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Interested or not in Lily's medicine cups, you'd certainly be interested in many of the Lily products now serving . . . and saving . . . in hospitals everywhere. Indeed, The Man With the Lily Plan has a whole host of helpful information and samples for your inspection. Won't cost a cent, either. Just write us on your letterhead. *Lily-Tulip Cup Corporation, Dept. MH - 1, 122 East 42nd St., New York 17, N. Y.*

REFLECTIONS ON HOSPITAL LIGHTING

1. LIGHTING PUBLIC SPACES

HOWARD HAYNES and K. A. STALEY

HOSPITAL lighting systems must satisfy the visual needs of three groups of people—the patients, the staff and visitors. The patients, until they feel well enough to read, probably want low level lighting. (Psychologists describe it as the "crawl-into-a-dark-hole-to-suffer-alone" tendency.) The staff, on the other hand, needs, in general, high level lighting to permit quick seeing and accurate examination. Visitors look more for mood; they like to find the hospital a "warm" cheerful place or a "cool" cheerful place, depending upon the season and the latitude.

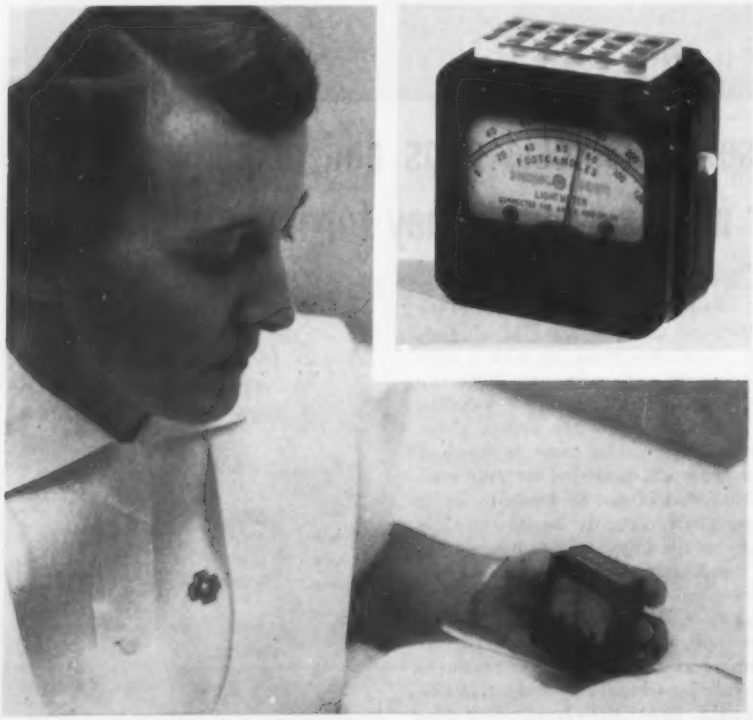
In this one particular—"warm" or "cool" atmosphere—lighting and decorating are invariably combined to produce the desired effect. In the articles to follow, the reader should keep this dual rôle of lighting and decorating constantly in mind. Lighting systems as such are never alone in their impact on the user; they must always be considered as only a part of the whole environment.

The levels of lighting for seeing tasks in hospital practice have increased through the years, as they have in commercial, industrial and residential interiors. The values prescribed in Table 1 may seem high to some administrators who have lived under lights prescribed and installed 20 or 30 years ago. But like many another phase of building design, hospitals, of necessity, have speeded up their services. They have new standards to fulfill; they needs must adopt new lighting and decorating to quicken the eye and keep up the new pace.

As put by Ralph J. Cordiner in "New Frontiers for Professional Managers" (McGraw-Hill, 1956), "The third imperative . . . is the dynamic pace of technological change and the rise of research and innovation in ali fields. Very few substantial businesses today can expect to grow without a dynamic plan for continuous innovation in products, processes, facilities, methods, organization, leadership, and all other aspects of the business."

In the preparation of this material, the authors visited dozens of hospitals in dozens of states and drew upon their general knowledge of both U.S. and European hospitals. As developed

Footcandle readings are taken in a horizontal plane, as on a bed, with the cell of the meter horizontal. Inset: Vertical planes, such as headings on records, are equally important; here the cell is held vertically.



This is the first in a series of articles on hospital lighting. The authors are application engineers in General Electric's Nela Park lamp and lighting headquarters in East Cleveland. They have been gathering the material for the last three years. The MODERN HOSPITAL is presenting the articles serially as reference aids to the hospital architect, designer, consulting engineer, administrator or departmental executive who is planning new space or the relighting and redecorating of existing space.

TABLE 1—REPRESENTATIVE LIGHTING LEVELS IN HOSPITALS

(Footcandles on Principal Horizontal Plane)

Auditoriums	general lighting	10
Note-taking at slide lectures		1-2
*Autopsy room	general	30-50
table		200 up
Chapels	nave	10
pulpit		20
Classrooms		30-50
Consultation rooms	general	30-50
Corridors	working	30-50
general		10-20
at elevators		20-30
*near surgeries		50
Dining rooms		10-20
*Delivery rooms	general	30
Table-normal delivery		200 up
Elevators	freight, passenger	2-5
*Emergency rooms	general	50
supplementary		200 up
Entrances	main	2 up
emergency		3-5
Examining rooms	general	50
supplementary		200 up
x-ray, fluoroscopy		10
Kitchen	general	30 up
work tables		50 up
Laboratories	general	50
work tables		100
close work		100 up
Library	stacks (vertical illumination)	30
reading rooms		30-50
Maintenance Department	general	30
repairing		50 up
Nurses' stations	general lighting	20
desk area, charts		30-50
Offices	auditing, accounting	50 up
private, general		30 up
Patients' rooms	general	5-10
casual reading		20-30
examination		50-100
Pharmacy		30
Solariums		50
*Sterilizing room	general	50
*Surgeries	general	50-100
table		1800 up
	Brain and similar operations up to	10,000
Therapy rooms, Physical		20-30
occupational—general		30-50
work benches		50 up
machines		100 up
sewing		50-100
weaving		20-50
Toilets		10
Utility rooms		30
Lounge, foyer, waiting rooms		20
furniture groups, casual reading		30

*These are rooms in which a germicidal tube system is also recommended. Other space, such as communicable disease wards, some laboratories, and nurseries should also be equipped with germicidal tubes.

in the text, the ones which showed technical excellence in lighting almost always were contemporary designs, the product of architect-engineer-designer collaboration.

In these the engineer guided the designer and architect, particularly, in quantity and quality of light and lighting. A good electrical system design produced it. As a primary premise, there need be no part of the hospital which is either glaring or dim or dingy. The *designer,* among other things, sees to it that the lighting system has good design in its color, sculptural value, its form, and pleasing line. He sees to it that these are in keeping with furniture and fabrics and all the other elements of the room. The administrator visualizes all the parts together. He wants the system practical, easily maintained, and, above all, free of expensive frills, for he is the person who must live and work there after architects and designers depart.

The footcandle values of Table 1 set the brightness key to the various rooms. They are based on experience, economic balances, and today's technical knowledge. These, too, will eventually be scaled upward when we have cheap atomic power (to reduce power cost), electroluminescent panels (to simplify construction), and better methods of using modern building forms and materials. In a word, when practice catches up with technical knowledge, lighting levels in hospitals will be in hundreds where now they are in tens.

A good rule to adopt is that the illumination level should be specified to fit the seeing task. The values of Table 1 are more or less minimum design values. The footcandles-on-the-task factor is often the most difficult to establish in the lighting design. Experience, common sense, safety considerations, the age of the persons who are to be in the space—these and similar factors enter into any choice. Almost never is there "too much light," although this phrase is frequently applied when there is too much glare or there is an imbalance in the general brightness pattern of ceiling, walls, floor and work surfaces.

In public spaces, particularly, higher levels almost always produce better seeing conditions. The lobby and foyers

BEFORE: This is the lobby of a Chicago hospital—not the county morgue—before new lighting was installed.

AFTER: This is the lobby of the same hospital, looking not at all like a morgue, after the lighting was changed.

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are deep or windowless in contemporary buildings; the electric lighting often does all the lighting. It should be borne in mind that in these spaces the entering patient (and accompanying relatives) often get their first impression of the hospital. First impressions are vivid ones. They set a sort of mental pattern of initial likes and dislikes, which may be lasting; they are always important.

FILAMENT *VS.* FLUORESCENT

A perennial first question in public space lighting is the choice of filament *vs.* fluorescent lighting. There are some administrators who have had experience with the older types of fluorescent fixtures and have grown to dislike fluorescent light heartily. Their reasons are born of sad experience—the early bare-lamp fixtures did give foods, fabrics and complexions a weird color cast. Almost needless to say, the present-day de luxe fluorescent lamp has pretty well dispelled all the faults of bad color rendition. Today, de luxe fluorescent lamp lighting is on a par with filament lighting in nearly every application in hospitals, with the possible exception of operating rooms—local lighting for surgery—where the color corrected filament lamp light is still the best.

If the public space is air-conditioned, the fluorescent lamp's coolness is an important consideration two ways: for personal comfort and for the lessened air cooling tonnage required. In most interiors during relatively warm months, additional heat from any source is a matter of concern, with air conditioning or not. In this respect, the fluorescent lamp has an important advantage: The heat generated by a fluorescent luminaire is about half that of an incandescent luminaire producing the same light. In comparing the costs of filament *vs.* fluorescent systems, therefore, the reduced cost of compressors (smaller capacity) should be credited to the fluorescent lighting systems. It is sometimes a considerable item; it may even overbalance the low first cost of filament choice.

We have yet to see a hospital, however, in which the public spaces are not best lighted by a combination of fluorescent and filament lighting. As so aptly described by Dorothy Patterson, lighting engineer of Dallas Light and Power Company, in a recent paper on residence lighting:

"Most interiors . . . need three kinds of light—soft lighting of a general character; accent lighting for reading, writing and other seeing tasks, and 'sparkle' lighting to beautify some prized possession in the room."

In hospital public spaces, the same three kinds of lighting are desirable. At least two of them—general and accent lighting—are necessary. To use only one, either general or accent, may result in a sameness, a monotony of brightness we associate with "institutional" interiors of the old days. Filament lighting is still the best type for producing accents, like a floor lamp. As one designer expresses it, "try to supply pools of light" for desks, or for reading at a davenport. The "sparkle" lighting in public places is for that bas relief, for those flowers in a niche, for the hospital's "prized possession."

Preference for incandescent (filament) lighting is often solely based on economics; tight budgets may necessitate a choice of low first cost. Simpler construction of incandescent fixtures is another factor. (It's a lot easier to screw in a new light bulb than diagnose the possible ailments of a starter, a lamp, and a ballast in the old-style fluorescent circuit.) Also a comparison of costs may result in the choice of incandescent lighting owing to relatively few hours' use per year, or low electricity cost, or both, for lower maintenance labor cost.

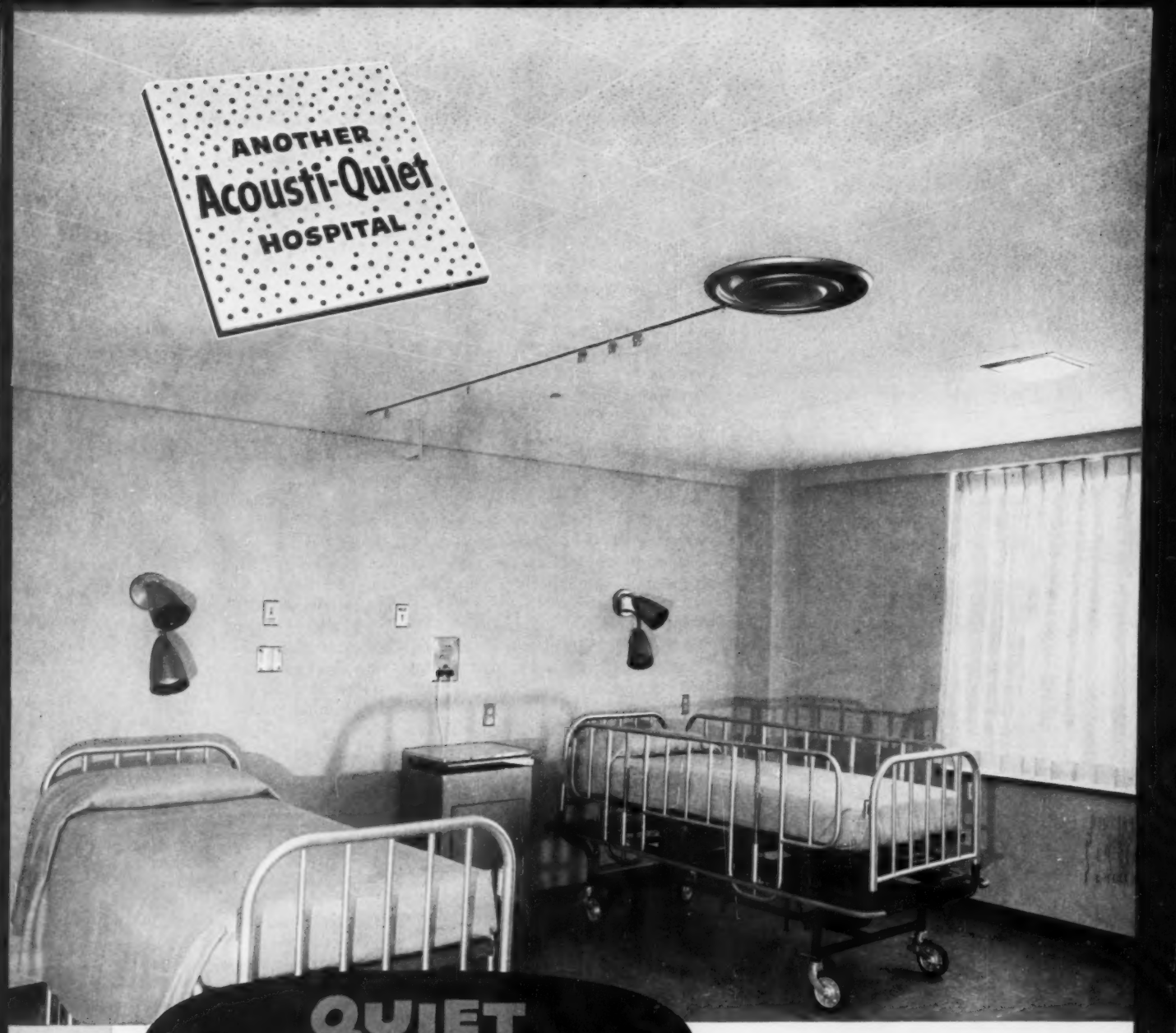
But there is another side, one of growing importance: styling and architectural unity. (These are completely decorative factors, utterly divorced from the practical ones of maintenance and quality of the switch, the wire, and the finish of the reflectors.) And the likes and dislikes of those who plan and maintain the building enter into this decision, too.

Take the single factor of hum in fluorescent fixtures. (This is one the maintenance man can fix only by installing new ballasts.) The usual 60 cycle hum is present in some degree in all fluorescent ballasts. In public spaces, the noise level may be high enough so that the hum is not noticed. But if the administrator happens along at 2 a.m. when all is quiet, the hum may seem to him to be very annoying. He may decide that all fluorescent fixtures are too noisy.

Certain ballast manufacturers rate their ballasts according to their sound-

Continuous-strip fluorescent lighting illumines the banquette on the far wall of this outpatient reception room. "Sparkle" lighting from the downlights in the ceiling gives both general and local lighting for reading.

Modern furniture, modern materials, and modern lighting combine in this waiting room to make a fresh, clean looking decor. Certified table lamps give more than 20 footcandles for casual reading. Luminaire gives general light.



QUIET Enters the Hospital

Semi-private room in the Indianapolis Community Hospital, Indianapolis, Ind., showing ceiling installation of Acousti-Celotex incombustible Random Pattern Mineral Fiber Tile.* **Architect:** Daggett, Naegele & Daggett. **Acousti-Celotex Contractor:** Hugh J. Baker & Co.

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producing proclivities—A, B, C or D rating. For patients' rooms and others in which "hospital quiet" is essential, ballasts of A or B rating should be specified. As a rule, the added cost increment is so little that it would be well worth while to specify in the general electrical plan that no ballasts rated less than B be purchased for any purpose.

For the general lighting in public spaces, there are many excellent filament and fluorescent luminaires available. It is our feeling that conventional commercial equipment in good taste is perfectly adequate for the purpose; there are many well engineered, quality products. The architect and designer, however, can supply a missing ingredient to most public space designs by building around the luminaires wood or other framing to soften the harsh lines of suspended fixtures, for example. Even luminous ceilings benefit by this treatment. Their usual metal frames garnished by a wood perimeter make a decorative note sometimes called "romantic," but perhaps better described as "naturalistic." (Wilbur Riddle, A.I.A., resident architect, Nela Park, and Thomas Mackesey, dean of the school of architecture, Cornell University, are users of this technic.)

Modern styling is an asset of importance in a luminaire. In this regard, most lighting experts can tell the age of a hospital by the style of light fixtures in it. Here are some questions to apply to the final design: Does the public space gain in architectural beauty by the lighting system? If you could remove the lighting, would the room be less attractive? Does the lighting look dated? (These primary questions apply to old as well as new space.)

DOWNLIGHTS

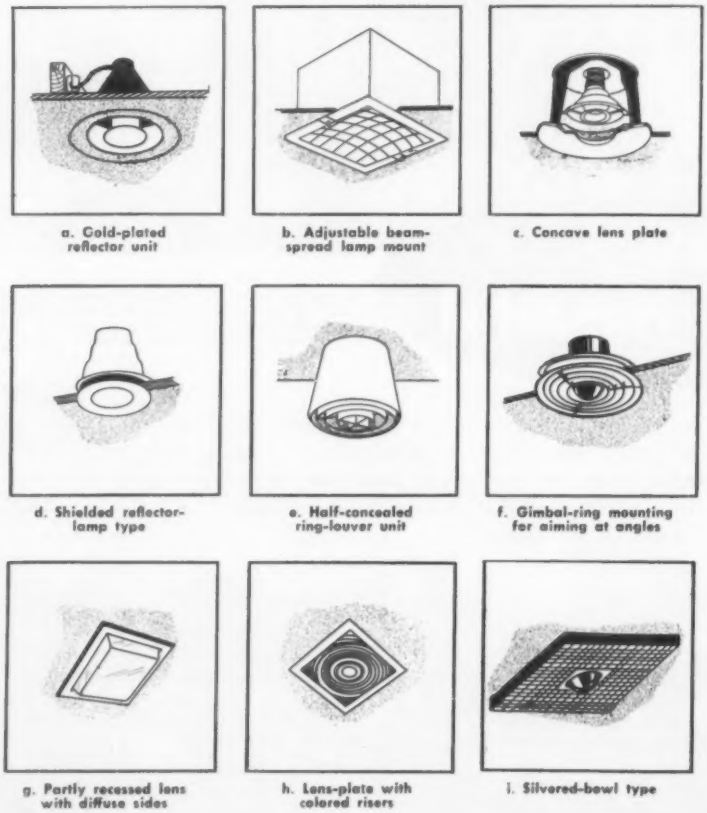
A well developed form of lighting element is the downlight. Architects and industrial designers have made wide use of it in public spaces such as lunchrooms, lobbies and adjoining corridors. The clean, simple lines add considerably to the appearance of many rooms. The downlight fits in well with block forms of ceiling materials and glass blocks. They can be easily cleaned and relamped. Representative lighting levels are possible. Combined with long, fluorescent luminaires, they accent furniture groups and decorative ensembles—flowers, shrubs, statuary and memorial plaques. For the last-mentioned, a type with a gimbal-ring mount for the reflector or projector lamp, one that can be aimed at an angle, is generally specified.

Some of the forms are illustrated. Those with unusual design include a type with a lens-plate with colored risers. When this is viewed at usual angles, it appears to be pleasingly tinted, although the light is unchanged. Another type shown has a concave lens-plate. This has new advantages of low-brightness-toward-the-eye on its far side, and surprisingly high efficiency to boot. Cover plates vary in shape and in light-control properties. The simplest of all is a frosted (top side etched) glass plate. This does diffuse the light some, but it always seems somewhat glaring and may have an uninteresting appearance as well. An improved form is the white glass plate, which diffuses the light more completely. A third is a glass plate with the louver pattern photographed in the glass itself. More decorative forms include configurated glass, metal-ribbon grids, or plastic grids, known as "egg-crate" but better called "lattice louvers." In general, a choice of cover plate material which is similar to the styling of other luminaires in the same wing or department, is desirable.

Metal ring-louvers are also handy devices to be used in downlights near a wall, such as above a mirror back of a lunch bar. Colored metal adds a desirable touch to these. Circular fluorescent lamps in downlights are a new and useful application. Their long life and low brightness are important advantages. They give the dramatic downlighting effect over lunch counters, for example, without the usual heat, as from any filament downlight close to one's head.

One type of downlight illustrated employs a gold-plated reflector. The effect is a psychologically warm light, eminently suitable for lighting in a lobby done in a warm color scheme, for example. Some architects also embellish downlights with painted or appliqué metal ornaments on the surrounding ceiling. This adds a touch of refinement which may well be worth much more than it costs.

SKETCHES OF TYPES OF DOWNLIGHT



a. Gold-plated reflector unit
b. Adjustable beam-spread lamp mount
c. Concave lens plate
d. Shielded reflector-lamp type
e. Half-concealed ring-louver unit
f. Gimbal-ring mounting for aiming at angles
g. Partly recessed lens with diffuse sides
h. Lens-plate with colored risers
i. Silvered-bowl type

GENERAL LIGHTING

The size and shape of fluorescent lamps practically dictated the design of new forms of luminaires of large area and low brightness for general

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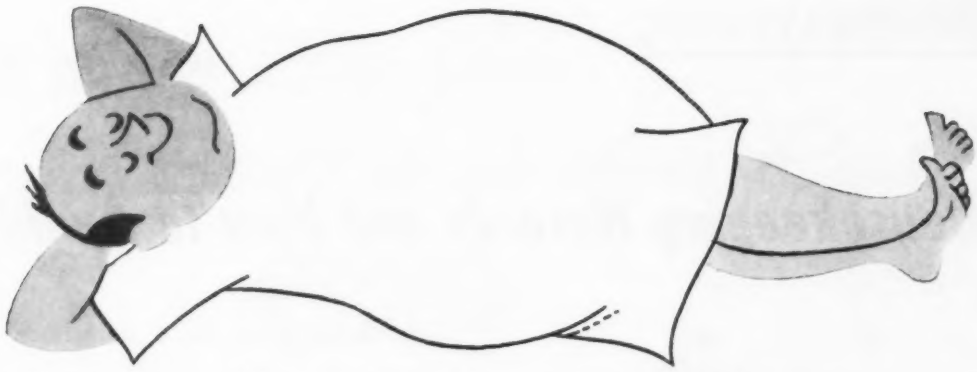
Solariums, staff lounges, and reading rooms for ambulatory patients should contain two or more types of lighting, as this one does. The overhead system (double-lamp troffers) produces pleasing brightness to the space generally, while portable lamps flanking the sofa and on occasional tables add appreciably to the 20 footcandles from above.

lighting. Some are illustrated, which are good choices for ceiling patterns, perhaps further concealed by wood frames, as mentioned. One modern concept is to consider them as so many blocks of light—modules of luminosity—with which to form a pleasing ceiling pattern in a relatively large area. In room-sized form, they become luminous ceilings, glass or plastic panels made from 2 feet by 4 feet or 4 feet by 4 feet or other sizes of units. When lamps are dispersed over the entire ceiling above, high footcandle levels—a hundred and up—can be produced. The effect is not glaring, if the installation is properly engineered. This form of lighting is frequently the finest of all answers to the room with ducts and pipes, otherwise hard to conceal.

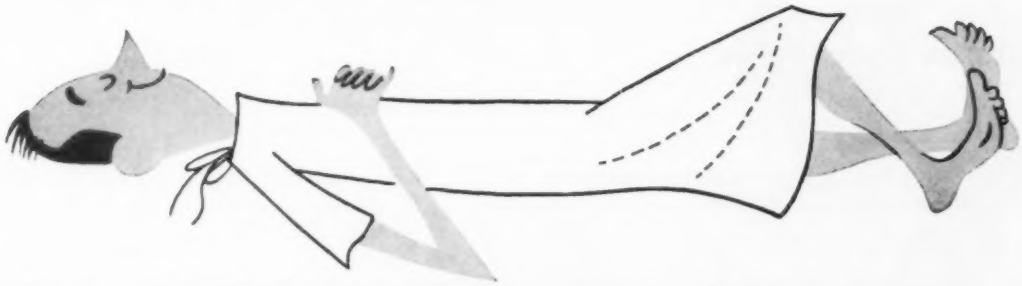
A number of manufacturers now have modular forms which can fit practically any shape and size of ceiling. The "floating" ceiling, in which the combined panels do not come out to the walls, aids maintenance, simplifies and reduces installation costs, often has a more pleasing appearance than wall-to-wall types. For auditoriums and classrooms and large offices, vertical members, which cut the luminous ceiling into segments, reduce large visible areas and reduce noise. These are generally of perforated metal or other acoustically-treated material. One form connects the perforated metal fins to the air conditioning ducts, with unusual appearance and cost advantages.

The classicists built buildings so that they looked good in the daytime. They had as many windows as were necessary to see to get about. The contemporary hospital architect with highly refined electric lighting at his command can and must build his hospital buildings for 24 hour viewing and functioning. It is not a 9 to 5 (daytime) conception; therefore, he should start from the beginning with electric lighting ever in mind. The best lighting is none too good for any person in a hospital, patient or not. Electric illumination in hospitals has graduated from the class of utility it once was. High quality lighting and decoration can literally transform ordinary looking rooms into bright, pleasant places in which to be. The psychological effect of a bright, colorful environment is important to all.

We wish to emphasize again the loftier concepts of the bilateral, architectural expressionisms of light and color, form and texture, good scale and good taste. In the hospital, by the very nature of the surroundings and the inner stresses and strains of the patient and his visitors, what and how he sees is extremely important. The patient may be an occupant for a short time only, but his recovery is without a doubt hastened by being "immersed" in pleasant surroundings. Lighting and decorating are environmental factors of great significance. A thorough knowledge of both is more necessary to the hospital planner today than ever before.



Fat or lean...they both rest better



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Housekeeping Hazards and How to Avoid Them

Housekeeping can be a dangerous business but an intelligent preventive program and awareness of potential hazards can keep them to a minimum

GEORGE S. MICHAELSEN

NOT SO long ago, a custodial worker complained to his executive housekeeper about general ill health that had persisted over a period of several months. He had noticed, however, that he felt worse after working in the tissue laboratory, and he wondered if there was any connection between the two. A follow-up of the suggestion seemed warranted, and it was discovered he had found that xylene was an excellent wax solvent and was, in effect, washing the floor with it to remove the wax accumulations.

COULD HAVE CAUSED FIRE

Xylene is a volatile coal tar solvent and dangerous to health in concentrations of about 0.02 per cent in air. Atmospheric samples collected while the worker was cleaning the floor with xylene showed that he was exposing himself to a concentration several times greater than the maximum allowable. He was not only endangering his own health, but also was creating a fire and explosion hazard in the tissue laboratory.

This recounting of an actual happening leads one to consider other materials with which housekeeping employes come in contact that are dangerous to their health.

Mr. Michaelsen is associate professor, School of Public Health, and industrial health engineer, Students' Health Service, University of Minnesota.

This paper was presented at the section meeting of the National Executive Housekeepers Association, Upper Midwest Hospital Conference, Minneapolis, 1956.

SOLVENTS

Volatile solvents are useful tools in the housekeeping field, but they must be used with extreme discretion and caution. They present either a health hazard to the user or a fire hazard, and sometimes both. Of the solvents commonly used in cleaning, carbon tetrachloride is the most dangerous from a health standpoint. It has found rather wide acceptance because it is not inflammable, and it is an excellent solvent for spotting furniture, draperies and rugs.

A large number of deaths have occurred throughout this country from the use of carbon tetrachloride for dry cleaning purposes, and even from relatively small spot removing operations. Here are a few examples from a list of 147 deaths caused by carbon tetrachloride exposure which one of my students tabulated a few years ago. Two women cleaning furniture, one man cleaning an office, 16 persons using carbon tetrachloride fire extinguishers, one man who soaked a mop in carbon tetrachloride, one man cleaning glue off a newly laid floor, two janitors cleaning floors, two persons removing paint, one mechanic cleaning machinery in a small room, one refrigerator repair man cleaning a refrigerator, one electrician using carbon tetrachloride to dry an electric motor.

The list goes on and on. Carbon tetrachloride should not be made available to the housekeeping personnel for any purpose. There are suitable substitutes available on the market that virtually eliminate the hazards.

Another extremely dangerous solvent that may find use in housekeeping departments is benzol. Benzol is also an excellent solvent and is a common constituent of paint removers. In addition to its toxic properties, benzol is extremely inflammable. Benzol's principal effects are on the blood and blood forming organs. It is reported to have a long delayed action so that the effects of over-exposure may not become apparent until months or even years after the exposure.

Other solvents likely to be used by housekeepers, of less importance from a health standpoint but dangerous because they are fire hazards, include toluene, xylene, acetone and alcohol. Many solvents have a tendency to remove the natural protective oils from the skin, and thereby increase the possibility of troublesome dermatitis. If it is necessary to use solvents in housekeeping operations, they should be carefully selected so as to present the minimum poisoning and fire hazards. When they are used the worker should be provided with solvent-resistant rubber gloves to eliminate skin contact with them.

ACIDS AND ALKALIES

Housekeeping personnel comes in contact with a variety of acids: acetic acid (vinegar), hydrochloric acid (muriatic acid), and a wide variety of bleaches. The main hazard here, to sensitive individuals, is dermatitis. This can be minimized by protective gloves and hand creams. A similar situation exists with the caustic cleaners such as

ammonia, washing soda, borax, trisodium phosphate, and lye.

INFECTIOUS WASTES

In the hospitals giving care to patients suffering from communicable diseases, housekeeping personnel has some concern over the handling of infectious wastes. Prime responsibility for preventing the spread of communicable diseases rests with the medical and nursing staffs. If isolation technics do not break down, there should not be any hazard to the housekeeping personnel. It would be well, however, for the housekeeper to check on isolation practices to reassure herself that the procedures are actually carried out and to serve as a reminder to the medical and nursing personnel that they have a responsibility to other personnel on the hospital staff. In this connection, it is helpful to immunize the housekeeping personnel against typhoid, diphtheria, smallpox and tetanus.

INSECTICIDES

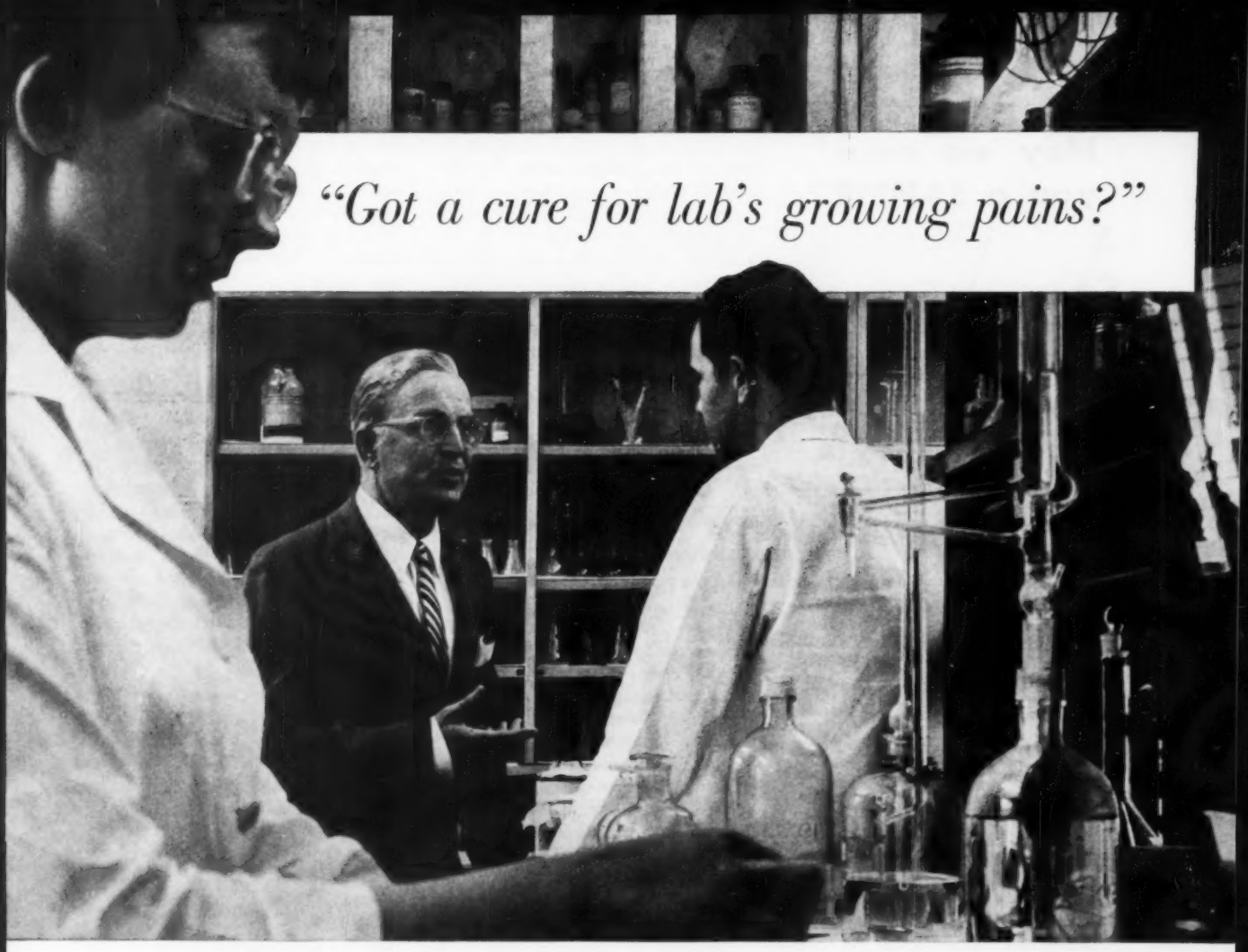
The increasing amount and variety of insecticides made available in recent years have introduced potential hazards to housekeeping personnel. Fortunately, a number of the highly effective insecticides are quite harmless to human beings. However, there are also some that are poisonous and should not be used by housekeeping personnel in occupied buildings such as hospitals. It may well be that for the smaller institutions the solution lies in having the work done by qualified and licensed exterminators or pest control officers. In any case, the executive housekeeper should be familiar with the toxic properties of insecticides.

The insecticides can be grouped into two classes, organic and inorganic compounds. The vast majority of them are organic compounds. A number of these insecticides are complex chlorinated hydrocarbons. Aldrin, dieldrin, chlordane, lindane, DDT and methoxychlor are the commonest of this type which are useful for killing household insects. These materials are poisonous to human beings also. Aldrin, dieldrin and chlordane are too dangerous to use in a hospital. Lindane, DDT and methoxychlor may be used if extreme precautions are employed to avoid contamination.

CAUTION ON VAPORIZERS

A word of caution should be given on the use of lindane vaporizers. When these devices first came on the market it was apparent that there would have to be some way of controlling the amount of material vaporized and that certain locations should be avoided. It was suggested that the rate of vaporization should not exceed 1 gram per 15,000 cubic feet of space per 24 hours and that there be thermostatic controls to avoid overheating the lindane. As experience with these devices is being gained, it is becoming apparent that they must never be used where food is processed, served or stored. Nor should they be used in homes or sleeping quarters.

Parathion, diazinon, dipterex and malathion are examples of organic phosphate insecticides. These are extremely poisonous to human beings and none of them should be used in a hospital. For example, recently one of our research workers spilled one small drop of an organic phosphate insecticide on the back of his hand. He was unaware of the incident until he began feeling ill and recognized the symptoms of poisoning by the insecticide. He immediately cleaned his



"Got a cure for lab's growing pains?"

He has, indeed! *This* administrator is ready. Fact is, he's been waiting for his "patient" to complain.

How did he prepare himself? At the outset, he estimated the patient day load and the operating requirements of each department. But he also instituted regular and timely reports to relate the actual patient mix to the forecast. Reports, for example, which relate the utilization of Lab's services to kinds of patients.

With these *on time* facts before him, the administrator was able to predict that Lab's work load would continue to increase. And thus informed, he was prepared to adjust the budget and authorize added personnel and equipment—*before* the condition could become a crisis.

This is but one example of how proper figure facts can point up situations that demand administrative action. For further evidence, write to us today for your complimentary copy of "Better Patient Care Through Administrative Controls."*

**A paper delivered by John L. Mayer, Jr., at an A.A.H.A. conference, Orlando, Florida*

McBEE

Better patient care through administrative controls

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hand and sought medical attention. In spite of his prompt action he was quite ill for a few days. Just *one* drop of the insecticide! Fortunately, there are a number of excellent organic insecticides available that are relatively harmless to human beings and therefore suitable for use in a hospital. These include pyrethrin, allethrin, piperonyl cylonene, piperonyl butoxide, and rotenone.

The inorganic insecticides include calcium arsenate, arsenic trioxide, and a variety of fluoride compounds. These are all quite toxic to human beings and their use in hospitals is to be discouraged.

MISCELLANEOUS

Mercury is used commonly in hospital laboratories. Unless the technicians use extreme care, a laboratory can become heavily contaminated. This in itself does not present a hazard to the housekeeping personnel, but it is mentioned here because the maintenance of low atmospheric mercury levels calls for more than usual attention from the housekeeping personnel. It is commonly recommended, in addition to other things, that there be daily washing and weekly waxing of the laboratory floor to cut down the mercury contamination. So when such a request comes to the housekeeping department, it should be accepted as a legitimate request and as the executive housekeeper's contribution to minimizing the hazard of mercury poisoning of laboratory personnel.

Similarly, housekeeping personnel may have some contact with radioactive materials. Not long ago, radon gas—a by-product of radium—escaped into a hospital laboratory. As radon gas decays, it leaves behind a radioactive dust that contaminates everything on which it settles. The housekeeping department was called upon to help decontaminate the laboratory. The health physicist for the hospital gave the employes complete instructions on how to carry out the cleanup without exposing themselves to excessive radiation and without spreading the contamination to other parts of the hospital. In special problems such as this, the housekeeping personnel should be under the direct supervision of a person qualified to handle the situation.

HOW TO REDUCE HAZARDS

The foregoing may seem like a formidable array of hazards about to befall the housekeeping personnel. Fortunately, all the potential hazards are not likely to become real at the same time. Foreknowledge should, however, create an awareness of the accident possibilities and result in a course of action to minimize the actuality of the hazards. Here are some things an executive housekeeper can do to reduce the hazards in his or her particular area.

Custodial workers frequently have their own mixtures or pet cleaning compounds which they consider superior to anything on the market. Unless the housekeeper is absolutely sure there is no particular danger in the use of such homemade remedies, their use should be strictly forbidden. Recently a custodial worker prepared his own furniture polish. Before he had a chance to use it the bottle blew up. Fortunately, no one was hurt nor was there any property damage. It may have been a good furniture polish, but obviously it was a dangerous one. Stick to the commercially available products. On the whole, it is doubtful that a custodial worker will have a better material than is available from a manufacturer of such products. This, however, is not the complete answer since some of the commercial products *do* contain poisonous materials.

DO THESE FOR SAFETY

Insist on a declaration of contents. Avoid those containing highly toxic materials. Avoid completely the use of the most toxic and most flammable solvents as such or as mixtures with other cleaning agents. If in doubt, consult a toxicologist if you are in a hospital, or an industrial health engineer in your state or local health department.

Where there is a contact between harsh chemicals and the skin, insist on the use of protective creams, gloves or other garments as the circumstances may dictate. When the protection of personnel depends upon the action of others, such as with infectious wastes, make periodic inquiries to see that the proper procedures are actually being carried out. Be alert to possible work-related illnesses, by listening to employes' complaints of working conditions or ill health.

There are many potential occupational disease hazards associated with housekeeping materials and services, but an intelligent preventive program and an alert awareness of the danger can help keep them to a minimum.

NEW "CURE" DISCOVERED

for out-patient department ailments

Out-patient departments have long been plagued with a variety of ailments—not the least of which is irritatingly slow service. Hospital directors had little choice but to keep mum. Now a sure cure for these ailments is discovered—*this new kind of hospital counter!*

It was engineered and planned to provide the utmost in open friendly service for the patient . . . the maximum in employee comfort . . . all at a space saving and at minimum cost to the hospital. It has the rich appearance and beauty of a custom counter (at a mass-production price). It is a complete working station . . . ideal either for out-patient or **general use.**

The clerk *always* faces the patient—ready to serve . . . has records, cash drawer and all facilities within arm's reach . . . works comfortably seated at all times, eliminating the usual standing and resulting fatigue. Patients are served more promptly, efficiently and courteously.

Get the full story on how other hospitals are benefiting from the effective cure this new counter affords. Write Room 1177, 315 Fourth Avenue, New York 10 . . . ask for case history CH1068.

Remington Rand

DIVISION OF SPERRY RAND CORPORATION

The Trouble With Nursing?

(*Continued From Page 60*)

047 who began the program, indicating a loss of 69,600 girls, or 32.9 per cent (see Table 6 on page 60).

While it cannot be hoped that all those who enroll will be able to finish three years later, anything that could reduce the high casualty rate would be helpful. Many of the drop-outs occur after the first year of training and thus all the time and effort invested in the student is lost because such a person has no status. It is also true that many drop out late in the first year when the grades they will probably receive become more apparent.

This survey of the present nursing picture, largely predicated upon a statistical analysis, is anything but encouraging in the area of meeting the problem of patient care with an increasing number of registered nurses. In a very real sense there is a tug of war going on in which the middle of the rope is adequate care of patients. Arrayed on one side are all of those forces that have been pointed out, such as many new hospitals with their added beds, greatly expanded facilities of old hospitals, increases in the number of admissions, patient days, and average census; the many demands for the nurse in industry, the veterans' hospitals, doctors' offices, public health, and so on, and increasing standards in the educational program that are discouraging diploma schools of nursing from continuing their long tradition of training.

On the opposite side is the registered nurse who is trying desperately to hold the line despite the fact that there are relatively few replacements for those who drop out for one reason or another, the fact that the medical profession gradually has shifted functions to the nurse that formerly were reserved for its own handling, and the need to keep up with all the modern methods of care necessary to serve the patients of the many medical specialties.

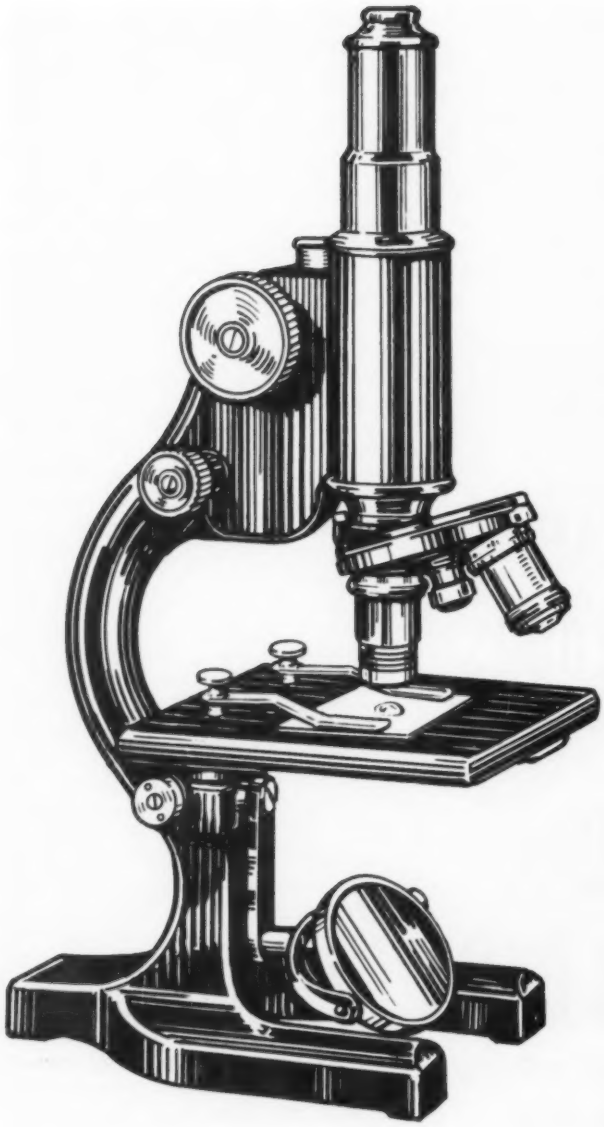
Fortunate indeed is it that there is sufficient rope to allow many practical nurses to take hold and lend their assistance, as well as the large nonprofessional group of well trained aides, and in more recent times the addition of the ward secretary. In the realm of medicine, assistance has come from early ambulation brought about by modern methods of care and the antibiotics that have greatly reduced the long periods of strenuous nursing care for many patients. It would be most helpful if, in addition to these factors already on the side of the nurse, there could be added the doctor, the trustee and the administrator, to rethink this whole problem as we go through the ever-changing process of providing patient care.

If we are to bring about any improvement in the kind and amount of care rendered to patients by registered nurses, there are several conclusions to be drawn from this statistical analysis.

1. We must make every effort, at local, state and national levels, to strengthen and retain most of the diploma schools that now exist. The dependence of the large hospitals without schools of nursing for the large number of nurses they employ demonstrates that every time a school closes we put a further strain on the diminishing nurse power. Administrators and directors of nursing in each state should give their very best in helping to solve this problem. The years just ahead will see many more girls graduate from high school because of the increased birth rate some 16 or 17 years ago, and we are, therefore, facing a great opportunity to increase the number of nurses, provided we retain or enlarge the schools now in existence.

2. Important as the addition of new hospitals and beds is in areas that formerly had no such facilities, it is even more important that additional schools be established, preferably in hospitals with censuses of 200 or more patients. This development might be materially aided if Hill-Burton funds, without the matching requirement, could be made available for the establishment of schools in areas and states that ought to have such facilities. We need additional schools and nurses just as much as we need new hospitals and added beds and these funds should be made available now.

3. The educational program of the nurse should be one of progression. The casualties in the student group are of such proportions that anything that can be done to reduce them is a step in the right direction. A great service would result if the diploma program could be so adjusted that at the end of the first year of training the student would have received the amount of work necessary to qualify her for the status of a licensed practical nurse. The curriculum during this first year might be adjusted to retain more of the students who now drop out because of



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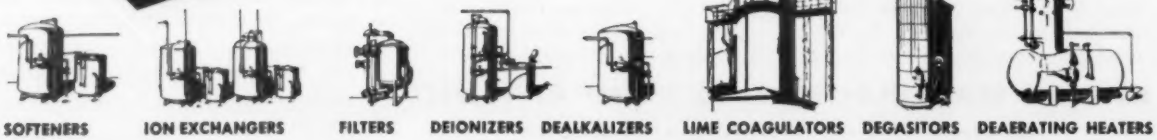

SOFTENERS ION EXCHANGERS FILTERS DEIONIZERS DEALKALIZERS LIME COAGULATORS DEGASITORS DEAERATING HEATERS

the heavy program and then place in the next two years additional subjects which will equip them for the status of registered nurse. This would then mean that girls who drop out in the second and third years will have a status, so they will not be lost to nursing as they are at the present time. It undoubtedly would encourage those who drop out toward the end of the first year to make the effort at least to pass the first stage of nursing.

The registered nurse, after the additional two years, would come out equipped to be the head nurse who would be able to direct the activities on the floor.

Beyond salvaging the students who drop out before completion of the three-year course, the training of the practical nurse could be brought within the hospital where her future service is so greatly needed. It would permit the present faculty of the diploma school to continue to teach the student in the first year without duplication of facilities or faculty, and would allow those hospitals that have the greatest desire to teach also to produce well qualified practical nurses. It would, therefore, allow for a greater flexibility for the training of students and a more economical use of the educational facilities in the hospital for the training of the necessary personnel for adequate care.

Following this, those who wish to go beyond the level of the registered nurse could by additional work in colleges qualify for a degree.

4. There could be a greater interest in the integration into high school curriculums of elective courses in subjects which lend themselves to nursing. We teach shorthand, typing, bookkeeping, and so on, but little effort has been made in the field of opportunities within the hospital. Certainly in the large metropolitan areas where there are numerous schools of nursing these courses would be of importance in stimulating interest in the opportunities in nursing.

5. In the larger metropolitan areas, there could be special night school classes for aides, allowing them to qualify as practical nurses, after giving such time and study as is necessary. This would allow the person who is ambitious and interested in improving her status to make some effort on her own beyond that which the hospital can give in the form of on-the-job training. This would further allow those who must work during the day to improve their status on their own time.

6. There might be a wider use of the licensed practical nurse and the trained nurse's aide, with the registered nurse being trained in her last two years toward the point of greater ability in administering a nursing unit as a head nurse. It is little wonder, considering how few are being graduated per hospital each year, that these girls suddenly find themselves thrust into positions of administrative responsibility. We ought to prepare the future registered nurse for this responsibility.

From this statistical survey and analysis of the nursing problem, it is evident that administrators will find it increasingly difficult to staff their hospitals in the future with registered nurses. There must, therefore, be a concerted action on the part of all of the interested persons who have been brought into focus—the nurse, the doctor, the trustee and the hospital administrator. This is not just a problem for those hospitals that operate schools of nursing. It is a much larger one for those that do not.

Handsomely textured Travertone, worked into a pleasing parquet pattern, adds distinctive beauty as well as comfortable quiet to the lobby of St. Mary's Hospital, Evansville, Ind. Easy to maintain, Travertone stays new looking for years. Architects on the job were Maguolo & Quick, St. Louis, Mo.; the acoustical contracting was done by Huntley and Blazier, E. St. Louis, Ill.

WHAT HAS BEEN DONE DECORATIVELY WITH ACOUSTICAL CEILING MATERIALS

The extensive use of acoustical materials, which provide the necessary quiet in hospitals and clinics, is creating new interest in the ceiling's decorative possibilities.

An unusually wide assortment of beautifully styled acoustical ceilings is now available from Armstrong. From dignified, marble-like Travertone, to the more casual full random pattern of Cushiontone, Minatone, and Arrestone, there is an Armstrong ceiling material to suit the styling of any interior. Factory finished, they need only standard maintenance; in addition, Armstrong acoustical materials can be repainted to match any color scheme without appreciable loss of noise-quieting efficiency.

For full details on the many decorative possibilities offered by Armstrong acoustical ceilings, plus a free job estimate, see your Armstrong Acoustical Contractor. For the free booklet, "Quiet at Work," write Armstrong Cork Company, 4201 Union Street, Lancaster, Pa.

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*TRADE-MARK

The Only Good Program Is One That Works

(*Continued From Page* 68)

keeper who may find them usable in another form. Many a torn sheet has proved usable when cut down to draw-sheet size.

The old adage, "A stitch in time saves nine," is certainly good to follow in a nursing home. Our maintenance men fix walks, porches, railings, floors, sanitary equipment as soon as anything is wrong. This is not only for economical operation but to prevent accidents. For the latter reason, we have locked the door on our floor-waxers, for polished floors are too dangerous. We use as nearly a nonskid wax as possible and apply it sparingly with a mop.

ADEQUATE FIRE CONTROL

Another precautionary measure is our adequate fire control equipment. This is regularly checked and always ready for instant use. Employes are instructed in its use and have regular stations assigned to them in case of emergency. An alarm bell may easily be rung from any area. In spite of the number of attendants on duty all night, we have a night watchman, who visits each part of the nursing home every hour, punching in at 11 different points at hourly intervals.

We are very proud of our nursing homes' "odorless" reputation. To keep them this way means work but it can be done. We have exhaust fans in halls, washrooms and toilets, as well as in room windows wherever necessary because of the patient's special condition. We also use electrically operated room sanitizers but we find the greatest odor fighters are cleanliness and sanitation. An exterminating company makes two visits a month to keep the nursing home free from pests.

Ease of maintenance as well as durability under hard use will dictate the use of fairly high priced materials for floors, walls and doors. Wainscoting along the walls is often advisable in order to withstand wheel-chair damage and also in those rooms where walls may be soiled by incontinent patients. Special consideration must be given to walls and floors which will clean easily and without injury many times and which will not absorb odors.

Good rollers should be placed on all beds so that they can be rolled away from walls easily, if they are so placed. In many nursing home plans, provision is made for free space on three sides of a bed. This is most desirable but many older folks have never before slept in single beds. They are uneasy unless one side of the "little" bed is next to a wall. Used to full-size beds, they feel "safer" if they have "only one side to worry about falling off of." During the day, it is sometimes desirable also, to move beds to one side to provide for a little "kaffee klatsch" or occupational activity.

Another thing not relished by old folks is air conditioning. We tried air conditioning in several wards with great benefit to those who suffered from the unusually hot weather, and last summer installed it in the entire hospital wing. We found it of great value to move in patients as soon as they showed signs of suffering from the heat. A few days or even a few hours brought them new vigor. So we decided to air condition the whole building this year—and were we surprised!

When carpenters appeared early this spring to prepare for the installation, so many residents protested that we stopped the work immediately. One of the main objections was that it would prevent their enjoyment of the porches, because the temperature change in going in and out would be too great. I admit that I had not thought of that, for I did not suspect that they would prefer hot air on the porches to cool air in the house. We found that nine out of 10 residents preferred fans to air conditioning so we canceled our orders for the time being and tried to find other ways of keeping cool. We found the solution lay in ceiling fans —the big, old fashioned kind. After a successful trial in several rooms and in one of the lobbies, we had many more installed and these, together with our existing system of exhaust fans, give our residents much more pleasure and comfort than the air-conditioned units which we have also retained. We have even had ceiling fans installed on the porches. Older people seem to prefer warm air in motion to still, cool air.

I realize that people from various parts of the country have very different backgrounds. Perhaps that is the reason our recreational problems seem so different from those which the planners advocate. Most of our residents have lived in and around St. Louis and southern Illinois. A few have come from greater distances, but practically all have been at one time or another from the Midwest. Some are city folk, some are country folk, but the great majority will not want to engage in active recreation! And *no* audience participation programs, please!

A few will like to take short walks around the block, even fewer will like to stroll farther than that. Little trips to the near-by drugstore, grocery or post office seem to be sufficient. We have tried to encourage gardening as a hobby, but after a session or two, interest waned and the high school senior we hired to help with the project soon became the sole gardener. No one wishes to play the piano, pitch horse shoes outdoors, or ring toss indoors; no one cares to play croquet if he can get out of it and we had to give up shuffleboard long ago. Painting and weaving are lost causes. A few have tried to interest themselves but just did not care for such things.

Jig saw and crossword puzzles, Chinese checkers, Flinch, Scrabble, Pinochle, crocheting, tatting, embroidery, making of aprons and quilt tops, wire working, and Bible study are favorite pastimes unless you include reading, walking or just sitting on the lovely porches and talking! No one ever seems to run out of things to talk about. Just try to "educate" them to interest themselves in the things the experts say they should do and see how far you get.

We have a "talking Bible" and a small library which is used to some extent. We are able to borrow books from the state library at Springfield and so add to our selection. Books in fine print and devoid of illustrations are naturally not popular when eyesight is dim. Magazines are liberally distributed about the home and the pictures, at least, are much enjoyed.

The spiritual well-being is not neglected for we have church every Sunday in one of our lobbies. Local pastors supply the pulpit talks and we try to give all denominations a chance.

Nurse notifier systems are usually advocated by the planners. Here is

Doctor, would it be helpful to you in your practice to know that there is a food available at reasonable prices in the stores the year round having these attributes:

1. High public acceptance as to flavor and palatability—billions eaten annually.

2. One of the best of the "protective" foods with a well-rounded supply of vitamins and minerals.

3. Low sodium—very little fat—no cholesterol.

4. Sealed by nature in a dust-proof package.

5. One of the first solid foods fed babies.

6. Can be easily digested by old folks as well as infants.

7. Can be readily eaten out of hand, in milk shakes, on cereals, or in salads.

8. Can be baked, broiled or fried.

9. Can be used as an ingredient product in breads, pies, cakes and desserts.

10. Useful in bland and low-residue diets.

11. Mildly laxative.

12. May be used in the management of both diarrhea and constipation.

13. Can be used in reducing diets.

14. Can be used in high-calorie diets.

15. Useful in the dietary management of celiac disease.

16. Useful in the dietary management of idiopathic non-tropical sprue.

17. Useful in the management of diabetic diets.

18. Valuable in many allergy diets.

19. Belongs among foods useful in certain acute intestinal infections.

20. A protein sparer.

21. Favorably influences mineral balance.

22. Useful in the management of ulcer diets.

23. One of the easiest of foods to eat or prepare.

FOR THE NAME OF THIS FOOD, PLEASE TURN THE PAGE.

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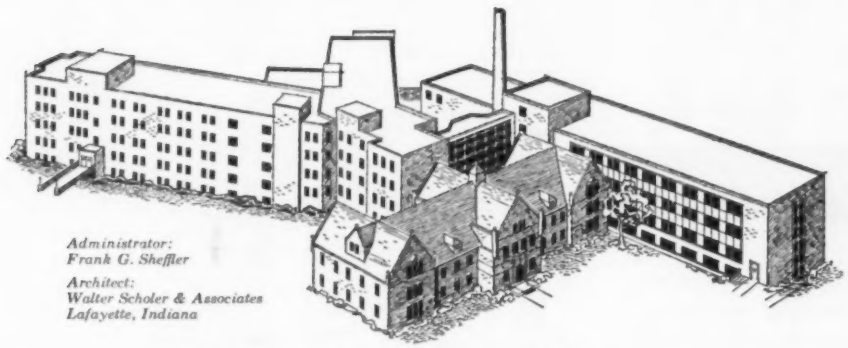

Administrator:
Frank G. Sheffler

Architect:
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Lafayette, Indiana

Reid Memorial Hospital, Richmond, Indiana

	1956 Campaign	1948 Campaign
Minimum Goal	$1,000,000	$ 750,000
Pledged	1,038,684	1,020,000

Eight years ago, Reid Memorial Hospital of Richmond, Indiana, surpassed its fund-raising objective and raised more than a million dollars for a new 100-bed wing. Because of the area's rapid growth, however, these facilities soon became inadequate, and a 33% increase in hospital use brought overcrowding to the critical point once again. In a letter to Ketchum, Inc., Board President E. Gurney Mann wrote: "Recalling your firm's very important contribution toward raising the funds in 1948, we are again coming to you . . ."

Despite complications due to strikes and employee layoffs in the community, the second campaign also raised more than a million dollars, following which Mr. Mann commented on the firm's "usual outstanding job as Professional Fund Counsellors" and extended the Board's "heartfelt thanks for a job beautifully done."

This victory, which will assure construction of a four story wing providing 144 additional beds, was achieved through the efforts of civic-minded volunteers who worked hard and effectively. Hundreds of citizens gave General Chairman Francis D. Gregg and other campaign leaders a standing ovation at the successful conclusion of the campaign.

If your hospital is planning to raise funds, we will be glad to consult with your Board at no obligation. Early planning will help to assure the success of your campaign.

another detail which we have found most impractical and bell systems are even worse. The "spoiled" patient who wants constant, even though unnecessary, attention and the senile one who does not realize how often she calls will cause many useless trips. The most efficient plan is to have enough nurses to cover the floor at regular, short intervals. At night, the slightest noise is heard by the nurse who works from the center of the long corridor and makes her regular rounds to each patient. Both our homes were originally equipped with nurse notifier systems but we found them inefficient and disturbing, so we no longer use them.

Night lights are not needed in rooms and, in fact, keep many patients awake. One of our homes has lovely molded and shielded corner ones, the other home has not. We prefer the latter. Halls should be well lighted and room doors left slightly ajar so that an adequate amount of soft light may filter in. Night nurses should be instructed to train their flashlights downward when it becomes necessary to use them. Thus the patient's rest is not disturbed.

Care should be taken that no obstructing furniture remains at night between the bed and the door or the bed and the commode. Many people arising in haste are slightly dizzy and may easily suffer a bad fall if their path is obstructed. Floors should be as nonskid as possible and scatter rugs should be eliminated. Granted they do make for a "homey" appearance but they are extremely dangerous and cause many a bad accident among people of all ages.

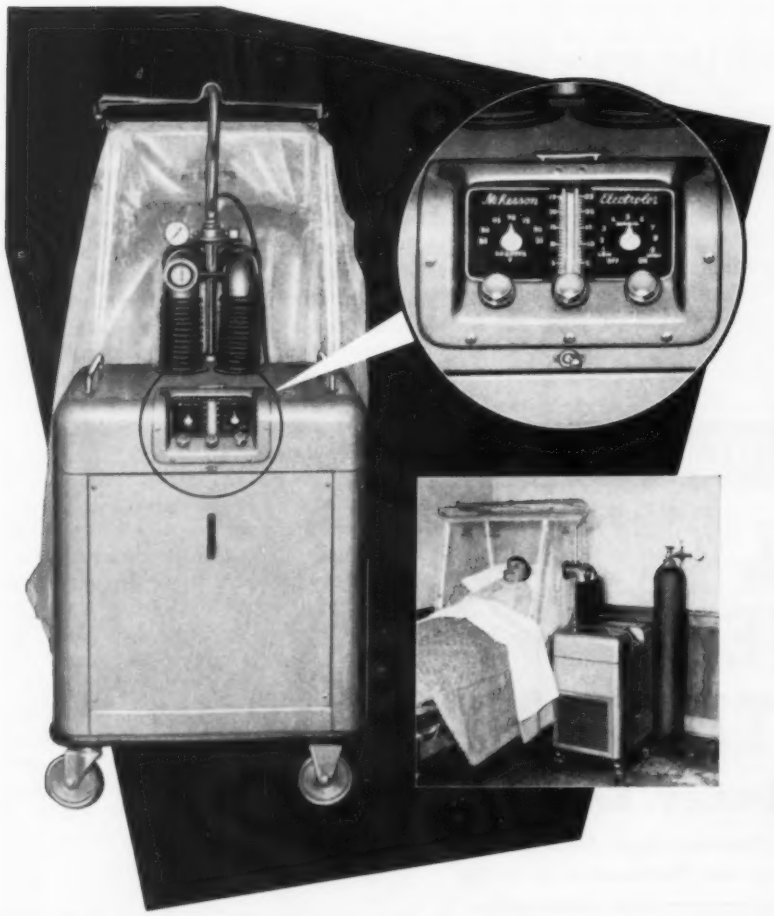
As to sizes of rooms, we think that private rooms can vary from 110 square feet to 120. Although 60 square feet is the minimum standard in Illinois, 75 to 80 feet per bed is better in wards. In planning new structures, I would plan the wards with not less than 80 feet, semiprivate rooms with 100, and private rooms with 120 square feet per bed.

Long, easy grade ramps should be built in instead of steps wherever floor levels change and, of course, hand rails here should not be forgotten. Hand rails should be provided in the toilet cubicles and washrooms. We like to use lightweight aluminum walkers further to ensure against falling. They are excellent in teaching patients to walk and invaluable as support for the infirm.

We must also disagree with the planners who advocate short corridors, for we much prefer long wide ones. In our experience a nurse can more effectively care for more patients if the corridor is long and straight. In our larger home, halls are long and the nurse's desk is located at midpoint. In the smaller home, short corridors radiate from the nurse's desk. Thus we have been able to compare the two in actual use and the long one is by far the more practical.

Halls should be pleasantly wide—at least so that two wheel chairs can pass each other. They should be well lighted, naturally or artificially. Narrow tables bearing lamps, flowers, magazines, ornaments, narrow benches, and pictures placed along the walls help to eliminate the "bare hall" look by breaking up the long line, yet they do not interfere with the use of the handrails.

One of the most helpful devices we have is our intercommunication system located in the office. Its lines extend to 12 parts of the building and save us a great deal of time and energy. We can check anywhere in the building at any time, direct various activi-



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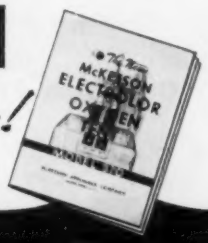

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ties, relay messages, receive word quickly in case of emergency. We have bedside telephones at our smaller home; incidentally they are so seldom used that we do not recommend them in planning a new nursing home.

It has been said that more small nursing homes serving smaller areas mean more localized residents, thereby making visiting more convenient and thus more frequent. On the surface, this may seem highly desirable, but such is not always the case. Just how often visits are helpful and just when the point is reached where they are not is the question that only the patient's condition can decide. In our two homes, we have plenty of experience with visitors from near and far, and often find that relatives and friends are harder to care for than the patient.

Frequent visiting is excellent from the standpoint of assuring the patient that he is not forgotten or neglected by family and friends, but too frequent visiting prevents integration with the new mode of life and often prolongs the period of adjustment.

Planners do not seem to realize that each home presents its own individual problem, *i.e.* background of area served, type, size, staff, outlook of owners and workers, and, of course, the problems which each patient presents. There can be no exact set rule—only general ones to be varied and changed as conditions themselves do. I am sure that even between homes in cities a few miles apart and even homes within the same city, distinctive differences and situations will be found. All that can be done is to set up a framework and work within its confines.

I feel that I cannot stress enough the practical value of having an alert, sympathetic staff, trained in the knowledge of what to expect and in patient handling of residents. Even from a completely hard-boiled standpoint, it is surely more practical to deal understandingly with the problems they present, to try to make them contented. Contented patients will live longer and give less trouble. Nursing homes are in business to keep patients alive, not just to take care of them until they die. To deny the right of the old to at least a certain measure of thinking and doing for themselves is to relegate them to the scrap heap; to offer them enforced ease and indolence is to hasten the decline by adding the burden of loss of individuality and purpose.

Persons should be encouraged to do for themselves as far as possible. Making their own beds and doing their own mending should not be required but at the same time, any who wish to do these chores should be permitted and even encouraged to do so. The janitor may have to sweep the porches over again after the resident is out of sight, but what matter? It was on the janitor's schedule anyway and the ambitious patient gained satisfaction from having accomplished something.

Licensing bureaus do not always consider, or perhaps are not fully aware of, the wide variations in physical conditions and mental alertness of the older people who are filling the nursing homes today. The bureaus' standards may be neither realistic nor practical in regard to the patient and yet such impossibly high standards may be required of the plant that no home offering services at modest rates could bear the cost of maintaining any unnecessary physical standards. Laws should be made and enforced in regard to sanitation, safety and adequate care and service but perhaps some leeway should be allowed the owner to carry out other services as he finds best in his particular setting.

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Who Has More Fun Than Old People?

(*Continued From Page 72*)

small sprays of tinsel strips which, come Christmas, will adorn the gift packages of one of New York's leading specialty shops. There was much chatter around the long worktable, and compensation not to be measured wholly by financial returns. As one 80 year-older put it, "It's almost like 'fancying up' gifts for the youngsters, like in the old days." A suggestion of moisture around the faded blue eyes, but a twinkle, too. "Anyway, it's good exercise for these." And she held up hands crippled with arthritis.

Those not engaged in some occupational or educational activity may be part of a group that receives new members, the Welcoming Committee, as it is known, or they may serve as members of the Hospital Visiting Committee, whose pleasure it is to pay occasional visits to those who are incapacitated or perhaps merely receiving temporary treatment.

Guests of Mary Manning Walsh are free to go and come at will. With every facility accessible within their own four walls, however, there is little inclination or need to travel afar, except perhaps for week ends or brief vacation periods with their friends or families. Too much of interest is going on at "home."

A shampoo or a manicure or a new hair-do is desired? The resident in charge of the beauty shop is contacted who makes an appointment with the outside beautician who is available at certain hours. It is as simple as that. Similar facilities are adapted to masculine needs.

DRESS SHOP IS HANDY

There is occasion for a new dress. A visit to the dress shop and consultation with the resident in charge proves productive. A completely new model is proposed, made to order from materials that have been donated. Better yet, here is something just received, excellent material and well tailored which, with some minor alterations, would be most appropriate.

Thus far masculine trade has not been directly solicited, but that inequitable situation is now being corrected. The men's shop adjoining the millinery salon operated by our friend Mrs. X is rapidly developing an enthusiastic clientele.

What about time off for a cup of tea, or some coffee accompanied by a bit of cake? The Home's coffee shop is open the greater part of the day with fixed nominal prices. Just the place to entertain friends or members of the family at lunch or for afternoon refreshments. A resident serves as cashier, with volunteers working behind the counter.

On the matter of refreshments, it became evident that something should be done about the doctors' endorsement of a spot of whisky, a cocktail, or a glassful of port to boost jaded appetites and physical fatigue toward the close of a full day. How much more beneficial to enjoy such relaxation in the company of congenial associates than to take it surreptitiously in one's room.

THE PRICES ARE RIGHT

The bar at Mary Manning Walsh, opened from 4 to 5 in the afternoon and from 7 to 9 in the evening, is as inviting as any you might find along the neighboring avenues. And the prices are right—no set schedule, for the cost of maintaining a liquor license would be prohibitive. The guest places what he believes to be fair in the little container on the counter and all is well —even if the final result is a drink on the house.

In reality, no artificial stimulus is needed to induce hearty appetites at Mary Manning Walsh. Its spacious, airy dining rooms, colorfully decorated, with added bits of cheer thrown in for good measure, such as ferneries and canaries, are appealing in themselves. Guests are seated at tables for six with smaller tables along the sides reserved for couples. The Sisters do the serving so that they may study the food habits of their guests and make sure they are getting balanced diets. In-between snacks, beverages and such are available through pantries provided on the residents' floors upstairs.

The spirit of community activity and interests characteristic of life within the three buildings that constitute Mary Manning Walsh spread to the world outside and particularly throughout its immediate neighborhood. Like other residences for the aged, there is a long waiting list. In fact, as a foretaste of happy days to come, a club for nonresidents has been formed,

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known as the Hi-Neighbor Club, available to those residents of the neighborhood who are already on the waiting list. Some 125 members of this group participate in the activities of the Home and are welcome guests at all entertainments. Some even work regularly for the Home while they wait for admittance. In fact, some of Mrs. X's very smart hats are designed by a would-be resident.

Outside contacts are also maintained through the publication of *Chat,* the Home house organ, which appears every other month. Publishing policies are established by a committee of three who, with an editor and an editorial board, assume the responsibility for its printing and distribution. In addition to sales at 10 cents a copy among the residents, it is mailed to other homes for the aged and to interested friends. Circulation runs into several hundred copies.

Someone has said that Mary Manning Walsh, like its own city of New York, will be something to marvel at once it is finished. But when will it be finished?

Probably never, at least as long as Mother Bernadette and the Sisters responsible keep coming up with new ideas, and the suggestion box continues to function. So much is yet to be done with definite limitations of time and money. For the modest income derived from those who can afford to pay—$150 a month—obviously does not begin to meet the budget. Incidentally, no down payment is required from those entering, nor is there any obligation to turn over capital funds to the institution. Fortunately, the Carmelites have friends, many friends.

In the meantime new plans are being studied, new approaches to the problems of geriatrics. Right now efforts are being made to organize a training program for employes to assure their better understanding of how to handle old people, also to make them recognize their own important part in creating a happy atmosphere.

Every day witnesses changes to encourage normal community living. With emphasis already on color, scarcely is the paint dry in one section than the scaffolding is transferred to another. Why? Because it involves change of pace, activity, awakens new responses, new interests. It represents life, a new life, a new world. Too. it represents love and it is love that makes the world go round.

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NEWS DIGEST

Illinois Hospitals Ask Subsidy for Nurses . . . More Negro Doctors Needed on Hospital Staffs, Catholic Conference Told . . . Fire Prevention Students Get Practical Experience . . . Three Doctors Tell How to Build an Artery Graft Bank

Illinois Hospital Association Will Seek Nursing Grants From State Legislature

SPRINGFIELD, ILL. — The nursing shortage in Illinois hospitals has become so critical that the hospitals cannot hope to solve it unaided. They must have the help of "state government, doctors, nurses, hospital management, and some of the major organizations of lay citizens interested in the welfare of this state."

Thus, Leon Pullen, incoming president of the Illinois Hospital Association, explained a seven-point program aimed at relieving the shortage of nurses, at a press conference held during the association's annual meeting here December 6 and 7. To illustrate his point that Illinois hospitals are in a bad way, Mr. Pullen stated that 13 hospital schools of nursing in the state had closed since 1950, without any new programs opening to fill the gap. Total enrollment in all schools, he added, had dropped by more than 500 students in six years while over the same period the state's population had increased by 657,000 and the total number of hospital beds in operation, by 5700.

First point of attack on the problem, said Mr. Pullen, is a bill to be presented to the state legislature when it convenes in January asking state financial grants for hospital schools of nursing. Specifically, Mr. Pullen stated, the association would like the legislature to subsidize hospital schools of nursing in the amount of $400 per year per nurse. However, association officials seriously doubt their ability to get any such amount; they consider it more likely that the grant will amount to $100 per nurse or, at most, $200. A subsidy of $200 per nurse, Mr. Pullen pointed out, would cost the state approximately $3½ million annually for the 6698 students in 72 hospital schools.

Asked by a newspaper reporter whether the subsidy—if it came to pass—would be passed along to students in the form of reduced tuition costs, Mr. Pullen looked inquiringly at Leonard W. Hamblin, the retiring president of the association, and Arkell Cook, Evanston Hospital, chairman of a special committee on nursing, and all three shook their heads. The grant, these officials agreed, would just about enable the hospitals to carry on the student nurse program, without reducing tuition. Pressed for details as to how they expect a state subsidy to help the hospitals recruit students if the students didn't profit by the subsidy, Mr. Pullen explained that the association felt recruitment would be stimulated "indirectly."

Illinois Hospital Association officers, left to right: Leonard W. Hamblin, administrator, Blessing Hospital, Quincy, immediate past president; Leon C. Pullen Jr., administrator, Decatur and Macon County Hospital, Decatur, president, and Rev. John Weishar, director of Catholic hospitals, Diocese of Peoria, president-elect of the association.

Other points on the association's program are: (1) more rapid development of practical nurse training courses; (2) more Illinois colleges and universities offering baccalaureate and graduate training programs to help meet the need for nursing school teachers; (3) an amendment to the Nursing Practice Act that would include doctors, hospital administrators, educators and representatives of the public, as well as nurses, on the state board of nurse examiners; (4) experiments

(*Continued on Page* 164)

Fire Prevention Students Get "Practical" Experience in Chicago Hospital Fire

CHICAGO.—Forethought paid off for Chicago's Grant Hospital last month. An intensive fire prevention program had trained nurses to act quickly in conflagration emergencies. When a night blaze broke out in the hospital, student nurses in pin curlers, jeans and bathrobes rushed 19 babies to safety.

Ten mothers also were moved from the maternity wing to smoke-free areas elsewhere on the floor.

The fire broke out in a penthouse that holds elevator machinery.

"We're very grateful to the Chicago Fire Department and to Lt. Robert McGrath of its fire prevention division for their help in getting our [prevention] program going," said Robert J. Nast, administrative assistant of the hospital. "Lt. McGrath has been out here four or five times supervising our setup."

Idaho Elects Officers

Officers of the Idaho Hospital Association, chosen at the 23d annual meeting in Boise: president, Irene E. Oliver (left), administrator of Magic Valley Memorial Hospital, Twin Falls; secretary-treasurer, Owen P. Hatley, director, hospital facilities section, state board of health, and president-elect, Sister M. Alma Dolores, administrator of St. Alphonsus Hospital at Boise.

Appointment of Negro Doctors to Hospital Staffs Needed, Chicago Conference Told

CHICAGO.—Although participants in the third annual Catholic Hospital Conference sponsored by the Catholic Interracial Council of Chicago appeared to agree that racial discrimination in appointments of staff physicians should be outlawed, few of them could suggest the means by which non-white applicants for staff positions might be assured of equal consideration.

This was the problem that confronted members of a discussion group on appointment of minority group members to hospital medical staffs, in the face of information that some 40 Negro doctors in the Chicago area "have indicated their willingness to apply" for staff posts.

About 60 administrators and administrative personnel from the Chicago area attended the day-long conference here in November.

Representatives of at least two hospitals, one a member of the medical staff, stated their hospitals had received no staff applications from Negroes. They were startled when a co-chairman of the Committee to End Discrimination in Chicago Medical Institutions contradicted them, and presented proof of his statements.

Dr. Arthur G. Falls, who also is president of the medical staff of Chicago's Provident Hospital, suggested, "Perhaps the applications never got to the right place. The question is: How will we implement these applications in the future?"

Of 17 Catholic hospitals in Chicago, only two have Negro physicians on their medical staffs, Dr. Falls said. These five men, plus three at a Jewish hospital, and another appointment at a second Jewish hospital, constitute the total of Negro doctors on medical staffs of Chicago hospitals, with the exception of those at Provident Hospital, according to Dr. Falls.

"In many parts of the country Catholic hospitals have been outstanding [in this aspect]," he commented. "Why in Chicago they aren't, I am unable to say."

One Sister indicated that a remedy could be effected if "His Eminence [Samuel Cardinal Stritch, Archbishop of Chicago] would say that every [Catholic] hospital must admit at least one Negro to its staff."

Dr. Falls, however, called this a let-George-do-it attitude.

A second Sister replied: "It becomes a problem of accommodating the men on our staff at present. Do we have room for another who might bring more patients, when there are no rooms in the hospital for them?"

"We realize you have a shortage of beds," Dr. Falls said, "but we would like to share in the shortage. Let us all get together and try to get more beds." He attributed the discrimination almost directly to the medical staffs themselves and added, "Up to this time we have not been impressed with the change of attitude of medical staffs. At Cook County Hospital any day there are at least a thousand patients able to pay their own way. But Negro doctors cannot get their patients into other hospitals."

A doctor in the discussion group also leveled criticism at his peers. "The doctors must be educated," he said. "They're fearful of their patients."

Commenting on the kind of white patient who would protest his doctor's treating a Negro, he continued, "If it comes to a point that you have a patient who thinks so little of your professional services that this would drive him out of your office, you're better off not to have him."

Members of two other groups during the conference discussed admission of minority group members as patients and as students in schools of nursing.

Panelists in a morning session on hospital experiences in dealing with members of minority groups demonstrated somewhat conflicting ideas on eliminating prejudice in hospitals.

Norman Brady, assistant director of Presbyterian-St. Luke's Hospital, although he said his hospital has "broad policies" of admitting patients, selecting staff members, and enrolling nursing students, deemed it "impossible for the hospital to live beyond the day-to-day attitude of the community.

"The attitude of the hospital cannot very well differ from the attitude of patients we have under our care," he added.

William Silverman, assistant to the director at Michael Reese Hospital, said, "Someone has to make the first jump." Mr. Silverman called for education of the "family group," meaning members of the hospital staff.

"We can't get across a program of integration unless we've convinced our

(*Continued on Page* 170)

Connecticut Association Elects New Britain Man

BERLIN, CONN.—Robert C. Kniffen, managing director of New Britain General Hospital, was chosen president-elect of the Connecticut Hospital Association at its 38th annual meeting here on November 15.

Charles V. Wynne, administrator of Waterbury Hospital, is president of the association. Trustees at large elected by the association are Dr. Albert W. Snoke, director of Grace-New Haven Community Hospital and president of the American Hospital Association, and Joseph P. Cooney, trustee of St. Francis' Hospital, Hartford.

Charles V. Wynne (right) was installed as president of the Connecticut Hospital Association at its 38th annual meeting. Mr. Wynne accepts the gavel from Andre Blumenthal, who retired as president of the association.

Named regional trustees were Richard O. West, administrator of Norwalk Hospital; Edith M. Oddy, administrator of Milford Hospital, and Richard J. Hancock, administrator of Lawrence and Memorial Associated Hospitals, Inc., New London.

Dr. Price Is Chairman of Joint Commission Board

CHICAGO.—In its annual election held here Dec. 15, 1956, Dr. Julian P. Price of Florence, S. C., was named chairman of the board of commissioners of the Joint Commission on Accreditation of Hospitals, succeeding Dr. LeRoy H. Sloan of Chicago.

Dr. Alexander M. Burgess of Providence, R. I., was elected vice chairman, and Stuart Hummel, administrator of Columbia Hospital, Milwaukee, was reelected treasurer.

All appointments become effective January 1.

Joint Commission Lists Standards for Organizing General Practice Section

CHICAGO. — Misinterpretation of standards relating to the organization of general practice departments in hospitals is a continuing problem, the Joint Commission on Accreditation of Hospitals said here last month.

In a bulletin, the commission emphasized that the general practice department is not a clinical entity and that responsibilities of the department are not the same as those of a clinical service.

"Because misinterpretation of the standards relating to general practice departments continues, the commissioners wish to reaffirm their stand on this matter," the bulletin said.

Standards for organization of the general practice department are as follows, it was reported:

1. The responsibilities of this department shall be limited to administration and education. It shall not be a clinical service and no patients shall be admitted to the department. If and when desirable, however, the department may be made responsible for conducting the outpatient clinic in whole or in part.

2. Since the department of general practice will not have a separate service, the members of the general practice department shall have privileges in the clinical services of the other departments in accord with their experience and training, on recommendation of the credentials committee. In any service in which any general practitioner shall have privileges, he shall be subject to the rules of that service and subject to the jurisdiction of the chief of the clinical service involved.

3. The medical staff should give to the general practice department such administrative responsibilities in the conduct of medical affairs as are desirable to meet the needs of the hospitals.

4. The Joint Commission endorses and recommends that departments of general practice be established in hospitals where the size of the hospital and the educational facilities make such an organization possible and feasible.

5. Any action to create a department of general practice should be initiated by the generalists on the staff of a given hospital.

6. A general practice department should have fair and equitable representation in all staff activities of the hospital.

7. A generalist should be granted hospital privileges according to his training, ability and demonstrated competence.

8. A well functioning general practice department in a hospital is considered an attribute by the Commission.

Supply of R.N.'s Shorter Than Other Personnel, New Jersey Study Says

TRENTON, N.J.—What about the nurse shortage? The New Jersey Hospital Association decided to find out just how the lack of registered nurses in this state measures up to the deficiency in other hospital personnel.

The registered nurses, in terms of numbers, were most conspicuous by their absence, although their shortage was outranked percentage-wise by occupational therapists, medical social workers, practical nurses, and dietitians, in that order.

In the survey interpretation, the N.J.H.A. pointed out, however, that, while the 70 hospitals that replied to the questionnaire had a combined shortage of 877 registered nurses, or 18.3 per cent of the stated need for nursing staff, the 21 hospitals that employed occupational therapists lacked only 17. But this was 28.8 per cent of the total number these hospitals indicated they needed.

"It should be noted, of course, that while some hospitals may not currently employ individuals in certain categories, developments in future years may be such that they will have need to do so," according to the association.

Of 4779 registered nurses needed among the 70 hospitals, only 3902 were available, the survey revealed.

In other staff positions, the number of persons needed, and those presently available, are as follows: practical nurses, 1713 needed, 1337 available; medical technicians, 487 needed, 406 available; dietitians, 180 needed, 141 available; medical secretaries, 261 needed, 223 available; medical social workers, 113 needed, 84 available; x-ray technicians, 239 needed, 213 available; occupational therapists, 59 needed, 42 available; medical record librarians, 106 needed, 92 available; physical therapists, 91 needed, 78 available; nurse anesthetists, 75 needed, 64 available, and food service supervisors, 102 needed, 97 available.

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Two Health Groups to Expand Benefits for Major Expense

WASHINGTON, D.C.—Expansion of benefits to provide coverage for major medical expense up to $10,000 has been announced by Group Hospitalization, Inc., and Medical Service of the District of Columbia, the Blue Cross and Blue Shield plans here.

In addition to the basic hospitalization and surgical-medical care plans, the major medical coverage will cover hospitalization and medical costs not included in the basic plans, and regardless of where the expense is incurred, it was explained.

Major medical coverage can be applied to charges for private duty nurses, physical therapy, home or office calls by physicians, and other necessary medical services and supplies, the announcement said.

Major medical benefits will be available when, during the period of 90 days or less, a subscriber incurs out-of-pocket expenses in excess of an agreed deductible amount, usually $100, for items for which major medical benefits are provided, it is stipulated in the agreement. "After payment of the deductible amount for which the subscriber is responsible, the major medical coverage will provide benefits equal to that portion of 'covered' charges, usually 75 per cent, agreed upon for the group portion of 'covered' charges, usually $10,000 for any one illness."

Top-Heavy Hospital?

A campaign for $8 million has been launched to obtain funds for construction of a new Mercy Hospital in Baltimore. Designed by two architectural firms, Taylor and Fisher of Baltimore and Westermann and Catalano of New York, the 21 story structure will have a capacity of 350 to 400 beds.

Illinois Hospitals Ask Nurse Subsidy

(*Continued From Page* 156)

with new ways of educating nurses so that an adequate preparation for bedside nursing could be given in two years, with students given the option of continuing one, two or more years to advance their qualifications; (5) better coordination of nurse recruitment efforts among the numerous professional and public groups, and (6) improvements in hospital personnel and salary policies.

On this last point Mr. Pullen explained that hospitals "must pay the salaries that will attract the professionals who can give the service our patients deserve and need." He asked for public understanding and support of the unpalatable fact that "salary increases are inevitably reflected in higher charges to patients."

Other things besides the nursing shortage are exercising Illinois hospitals, it became apparent during the first session when Arkell B. Cook spoke — with considerable bitterness — on "Handling Hospital Professional Liability Claims." The groans and grunts that provided a background accompaniment to Mr. Cook's remarks indicated that his audience suffered equally with him in regard to payment for liability insurance. What hurts even more than sextupled premium costs, it was indicated, is the fact that many insurance companies simply won't write this type of insurance. The trend in the courts to toss out the theory of immunity of charitable trusts shows no signs of being reversed, Mr. Cook reported. On the contrary, more and more states are subscribing to the opinion expressed by the Minnesota court that "we do not believe a policy of irresponsibility best subserves the interests of the charity."

Mr. Cook offered some suggestions for improving the situation, as follows:

1. Introduction of a deductible feature in insurance policies, *i.e.* the hospital to assume the first $1000 to $5000 of the loss, with the insurance company paying the remainder plus the costs of defense in case of a suit.
2. Sustained leadership by hospital administration in finding and eliminating the causes of accidents.
3. Careful record keeping which would defeat unfounded charges of negligence.
4. Safety training programs for new employes and retraining of older ones.
5. Closer examination of the credentials of physicians applying for staff membership.
6. Eliminating errors in administration of medications.

Whenever Anthony W. Eckert, director of Perth Amboy Hospital, Perth Amboy, N.J., takes the stage to exhort his fellow administrators to plan for disaster, he never fails to point out that "a disaster can happen anywhere, at any time to any community," and the last two times he has spoken in this vein a disaster has obligingly happened to prove his point. While Mr. Eckert was speaking in Kentucky last April, a tornado was sweeping through southern Michigan, and the day following his speech in Springfield, Chicago hospitals were called upon to cope with the victims of an elevated train wreck—the second such accident in three weeks. Some day the hospitals are going to have to pay attention to Mr. Eckert's pleas for organized, prepared, preplanned disaster programs—or else stop asking him to speak at meetings.

In addition to Mr. Eckert and Mr. Cook, delegates to the meeting heard Dr. Otto Bettag, director of the Illinois

Department of Public Welfare, describe the improvements that have taken place in Illinois mental hospitals; H. Robert Cathcart, administrator of Pennsylvania Hospital, Philadelphia, explain the experimental two-year professional nursing program that is being conducted in that institution, and John L. Brown, administrator of Rockford Memorial Hospital, Rockford, and John M. Stagl, assistant director of Passavant Memorial Hospital, Chicago, jointly discuss the importance to hospital accounting of "funding depreciation."

Not only the delegates but just about everybody in Springfield and its environs heard the banquet orator, Charles E. Irvin, chairman of the department of communication skills, Michigan State University. For an hour and a half, the leather-lunged speaker, abetted by an overtuned microphone, belabored his hearers with the importance of conciseness in communications. "If you have done the right kind of thought preparation," Dr. Irvin bellowed, "nothing is sacrificed to brevity."

Some ten thousand words later, he concluded: "Every administrator is also a teacher of attitudes and values and those of his staff can never be better than those inside himself. As far as communications is concerned, we don't need an education—we need a revolution." There were those among his hearers who were ready to start the revolution right there.

At the annual business meeting the Rev. John Weishar, director of Catholic hospitals of the diocese of Peoria, was named president-elect. Others named are: 1st vice president, Arkell B. Cook, administrator, Evanston Hospital, Evanston, Ill.; 2d vice president, Virgil W. Nelson, superintendent, Lutheran Deaconess Hospital, Chicago; secretary-treasurer (reelected), Delbert L. Price, administrator, Children's Memorial Hospital, Chicago. Trustees who will serve a full term are: Paul Bjork, administrator, Community Memorial Hospital, Sterling, and George K. Hendrix, administrator, Memorial Hospital of Springfield. Shirley Lindberg, administrator of Marion Memorial Hospital, Marion, was elected trustee to fill a term expiring in 1957.

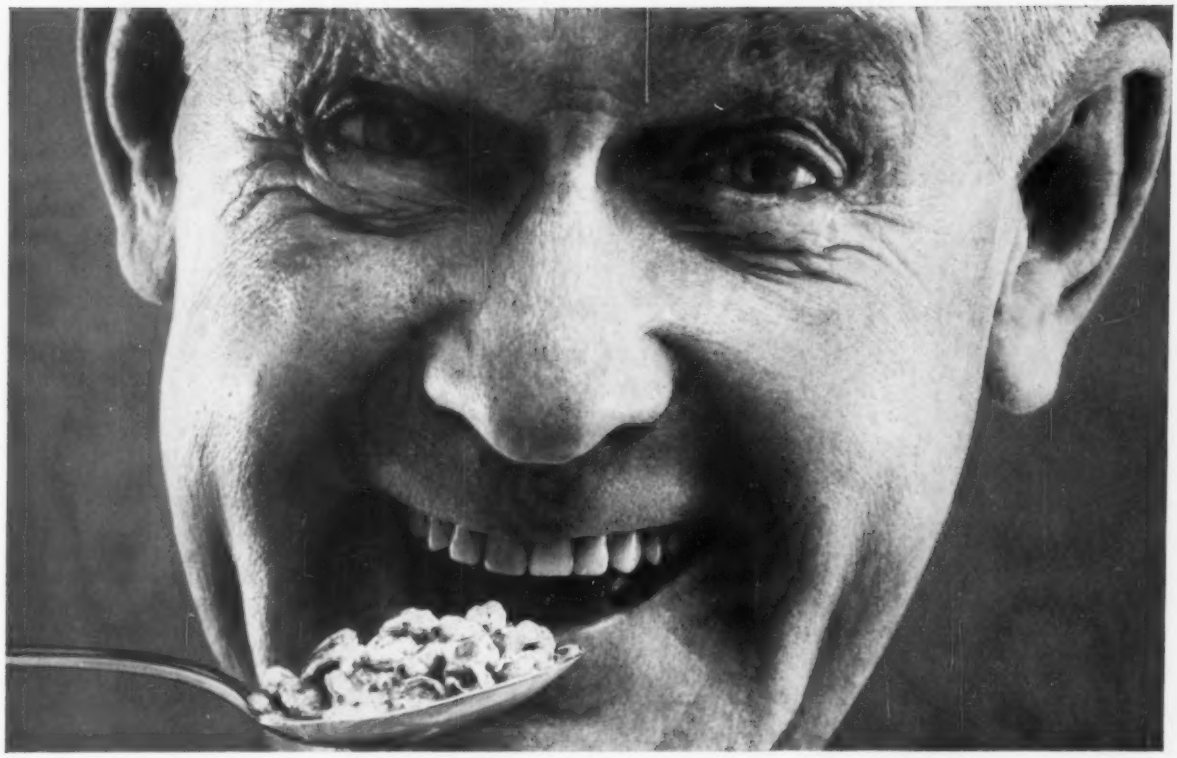
Uniform Accounting Set for California Hospitals

SAN JOSE, CALIF.—In order to meet the need for uniform hospital accounting practices throughout the state and to provide accounting counsel for the association's 341 member hospitals, the California Hospital Association established an accounting department at its annual meeting here, it has been reported.

G. A. Torrence, a certified public accountant on the staff of Blue Cross of Southern California since 1948, was chosen to head the new program.

Richard E. Highsmith, administrator of Samuel Merritt Hospital, Oakland, was named president-elect of the association. Other officers are president, Dr. W. W. Stadel, director of the department of medical institutions of San Diego County, and treasurer, J. E. Smits, administrator, Children's Hospital, Los Angeles.

Trustees elected at the meeting include John W. Doubenmier, administrator, Kern County General Hospital, Bakersfield; Glenn M. Reno, director, Children's Hospital, San Francisco; Richard W. Blaisdell, administrator, Peninsula Hospital, Burlingame, and Ralph J. Hromadka, superintendent, Santa Monica Hospital, Inc.



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Sodium Content of Quaker Cereals (Typical Analysis)	
Hot Cereals	**Mg/100 gms.**
Quaker Oats	3
Quick Quaker Oats	3
Quaker Enriched Farina	2
Pettijohns (Rolled Whole Wheat)	2
Ready-To-Eat Cereals	
Quaker Muffets (Shredded Wheat)	4
Quaker Puffed Rice (Enriched)	4
Quaker Puffed Wheat (Enriched)	6

Three Doctors Tell How to Build an Artery Graft Bank

CHICAGO.—An artery graft bank can be developed in almost any large community hospital at little additional cost and without employment of extra highly trained personnel, according to three Philadelphia doctors.

The three, Drs. William S. Blakemore, Herndon B. Lehr and Brooke Roberts of the school of medicine of the University of Pennsylvania, described the operation of a three-year-old artery bank at the University of Pennsylvania Hospital in the *Journal of the American Medical Association.*

They noted that the replacement of diseased, obstructed or injured major blood vessels with grafts from arteries of other persons has been widely accepted. However, they said, the grafts are difficult to obtain.

From their own experience, though, the doctors learned that any large hospital can establish a bank. Built in 1953 at a cost of less than $500, the Pennsylvania bank supplies 24 area hospitals as well as the university hospital.

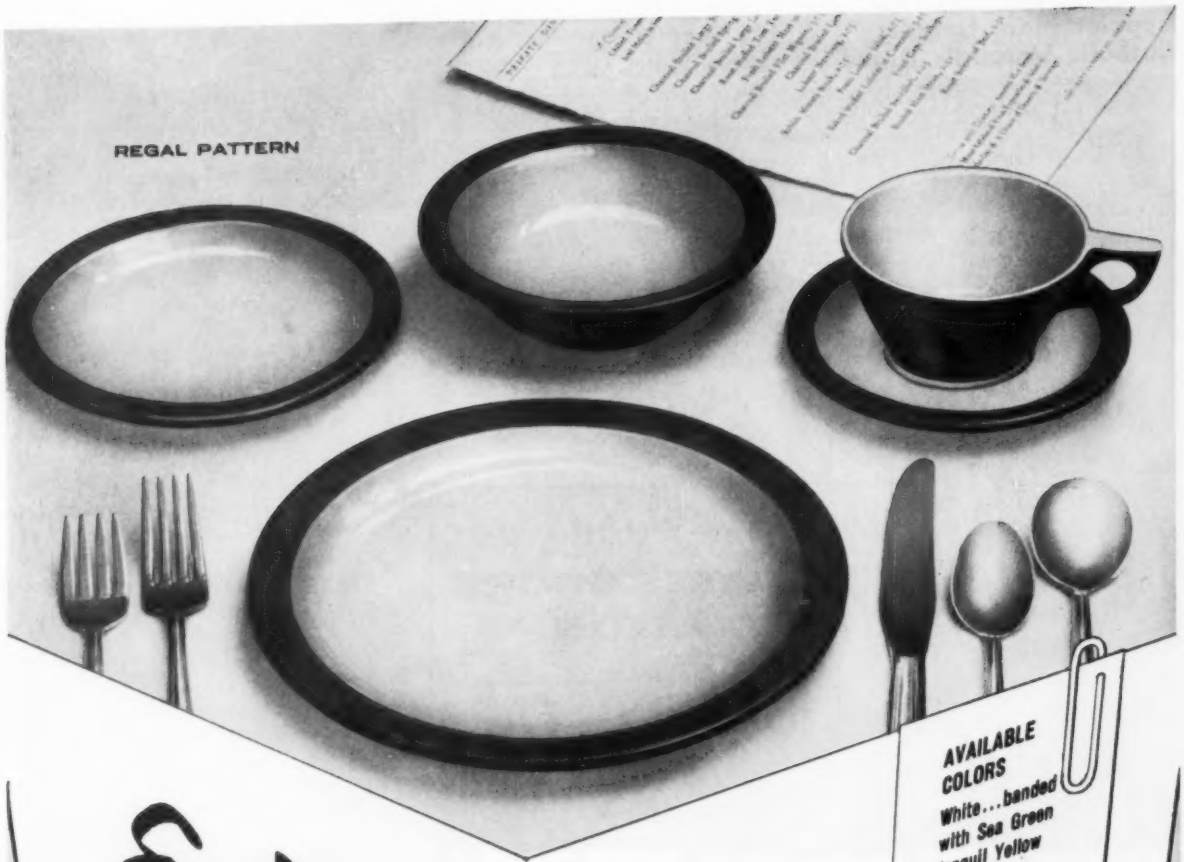
Cost of maintenance since the establishment of the bank has been very small, according to the doctors. Grafts originally were obtained under sterile precautions from fresh cadavers free of infection or other malignant disease. The doctors have since learned, however, that any human arteries not showing obvious abnormalities can be used safely.

Strict sterile precautions are no longer necessary in removing the arteries, they reported. After removal, the arteries are sterilized, placed in sealed glass tubes, quick-frozen in a mixture of acetone and dry ice, and slowly dried. The changes in procedure made it much easier to obtain the necessary number of grafts, the three doctors said.

Rhode Island Association Selects Dr. Scheffer

PROVIDENCE, R.I.—Dr. I. Herbert Scheffer, executive director of Miriam Hospital, Providence, was elected president of the Hospital Association of Rhode Island at its annual meeting here.

Other officers are vice president, Rev. Stephen K. Callahan, bishop's secretary for hospitals, and treasurer, Nicholas E. Janson, business manager, State Hospital for Mental Diseases, Howard.



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Appoint More Negroes, Catholic Hospitals Urged

(*Continued From Page* 158)

own staff that this is the right kind of program. Once we've convinced our own folks, let's try to educate the patients.

"How far do you go? It depends on financial circumstances. We have a long waiting list, so I can tell an intolerant patient he can go elsewhere if he doesn't like our policies. If our budget were tottering it might make a difference."

Mr. Brady contended that the hospital doesn't have the authority to educate the patient, except to the extent that he wants to be educated.

Clyde L. Reynolds, executive director of Provident Hospital, disagreed with "the idea of playing it softly." Since nurses manage to persuade patients to accept forms of treatment which often are unpleasant, Mr. Reynolds suggested that the nurses could influence patients in the area of tolerance. "When you think of all the things the dear little girls in white sell to patients, these [racial] problems become minor," he said.

Mr. Reynolds added, "When a problem comes up, it's one man's displeasure. We handle it that way."

Brother Constantine, administrator of Alexian Brothers Hospital, outlined his hospital's recent decision to end segregation of Negro patients. In the last three months, he said, it has been a hospital policy to admit Negro patients to wards on the same basis with other patients. This eliminates the former waste of beds which occurred when not enough Negroes were hospitalized to fill beds in the two segregated wards.

"It is amazing how readily patients will accept a policy if it is clearly stated and if the hospital lives up to that policy," Brother Constantine said. Of hundreds of patient questionnaires distributed, he said, not one complaint about the integration policy has been received.

Sister St. Alphonsus, assistant to the Superior at St. Bernard's Hospital, reported that Negro patients have been admitted regularly during the 15 years she has been associated with St. Bernard's.

Since 1952, Lewis Memorial Maternity Hospital has operated under a policy of nondiscrimination, according to Antoinette Rajek, director of medical social service at the hospital. Miss Rajek reported that 42 per cent of patients in 1955 were non-whites.

In a luncheon address, the Rev. John LaFarge, founder of the Catholic Interracial Council movement in this country, termed it the obligation of medical staffs to their hospitals to admit qualified men to their ranks.

Father LaFarge cited the progress toward admitting more and more Negro students to medical schools in the last 10 years. However, he said, there still are fewer than 200 Negro medical school graduates each year.

"The picture is not so bright for staff doctors as for medical schools," he lamented. "How can we get the best men qualified for these jobs if they never have a chance to be considered?"

Father LaFarge called on Catholic hospitals throughout the country to take "unified action" in a public statement condemning discrimination against members of any minority group.

This action is within the realm of Catholic action, he said, because discrimination is primarily a moral problem. Designation as the "universal church" does not mean the Catholic church merely "embraces or tolerates," Father LaFarge stated.

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Emotional Reactions Can Affect Surgery Outcome, Seattle Psychiatrists Say

SEATTLE.—Patients' emotional reactions to surgery may sometimes be strong enough to affect the outcome, according to two Seattle psychiatrists who spoke at the 10th clinical meeting of the American Medical Association here.

In fact, a patient's emotional reaction to a surgical operation may depend far less on the seriousness of the operation than on more complex emotional factors, said Drs. Norman Chivers and Theodore L. Dorpat.

The two doctors also referred to recent studies which show that surgery for children should no longer be considered an "unavoidable hazard in growing up" like measles and chicken pox. Children facing surgery should be given special attention, and in some cases nonemergency surgery should be postponed so that emotional difficulties can be cleared up first, they indicated.

Dr. Chivers, who is director of the Seattle Community Psychiatric Clinic for Adults and an assistant professor of psychiatry at the University of Washington, and Dr. Dorpat, who is an instructor in psychiatry at the university, pointed out a number of factors which should receive consideration in hospitalization of children, particularly for surgery.

Many children suffer from separation fears, or dread of being "abandoned." For this reason, visits by parents should not be discouraged. The two doctors particularly decried "absurd lying" to youngsters. They should be told just what is going to happen and why.

Drs. Chivers and Dorpat cited one study which showed that children who remained undisturbed after operations were those who had been given clear explanations.

Frequently, children may have hidden feelings of guilt which come to the surface when an operation is planned, since they may feel that the operation is a form of punishment. They may also be afraid of a minor operation simply because they have heard adults talking of someone who died in a hospital.

In adults, the physicians asserted, it is generally agreed that surgical results are better if workmen's compensation or other money claims are settled early. Loss of certain emotional advantages resulting from sickness is more difficult, they said. For instance, many persons rely on illness to get attention or sympathy, and fear they will lose it if they get well. One case described a man who did not want to be cured because while sick he could relax his lifelong effort to "prove himself a man."

Drs. Chivers and Dorpat also mentioned breakdown of "personality defenses." Some persons use elaborate subconscious methods for asserting themselves, as did a man who had been abnormally proud of his physique and ability to work hard. After an operation—although he was only slightly handicapped—he gave up completely and was almost an invalid, because he could not bear to be even a little less aggressive and hard working than before. Anesthesia is particularly frightening to people who believe that under its effects they may tell guilty secrets or behave in some way they normally would not.

The two psychiatrists recommended that every patient be studied before surgery to reveal any factors which might bring on any of the aforementioned reactions. Patients also should be encouraged to talk so that their special fears and problems may be revealed in time to be dealt with.

Children should have some ties with home, such as a favorite toy, and a "key member" of the family should be there when the operation is over.

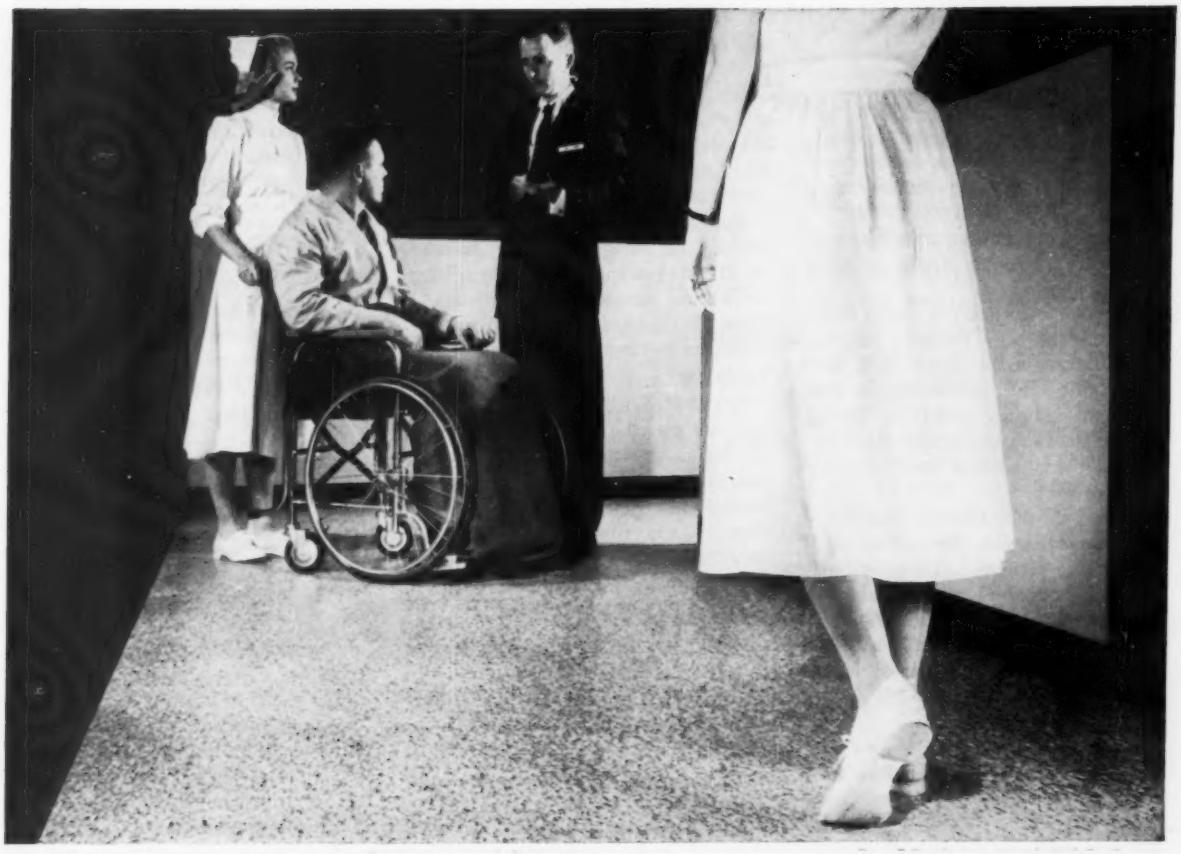
And in some cases, nonemergency surgery should be postponed, or avoided, in emotionally disturbed persons.

In another paper presented at the A.M.A. meeting, Dr. Dale Groom, assistant professor of medicine at the Medical College of South Carolina, Charleston, told the physicians that "quiet" hospitals are not so quiet.

Dr. Groom reported on an experiment that revealed that examining rooms, a heart clinic office, and the hospital library, among other places in the hospital, were two or three times as noisy as a house in the country, and not a great deal quieter than the hospital boiler room.

For purposes of comparison, Dr. Groom indicated the noise level in decibels inside a DC-6 airliner is 105 and in the hospital boiler room 100. Rustle of leaves in a gentle breeze measures 10 and a house in the country measures 30.

In the hospital the amount of noise measured in clinic examining rooms measured 72 to 75; surgical wards, 65; emergency rooms, 62; a private room, 60; a private room on an unoccupied floor, 40, and a soundproofed room, 35.



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Physicians Don't Tell, Patients Don't Ask, According to Survey

ATLANTIC CITY, N.J.—What laymen know about symptoms, etiology and treatment of common diseases, and what doctors think they should know, apparently are two different things.

This was brought out in a report at the American Public Health Association convention here.

Although a Cornell University Medical College team thought patients should know more about their ailments, "the fund of information that physicians indicated should be known by laymen was considerably more extensive than patients were actually found to have."

This was the gist of studies of physicians' views on medical information among patients and on clinic patients' expectations of medical care. The first study was made by Drs. George Reader, Lois Pratt, and Margarett Mudd; the second was carried on by Drs. Reader, Pratt and Arthur Seligmann.

In the second study, interviews with 50 patients at the medical clinic of a large metropolitan medical center revealed that, after seeing a physician for weeks or months, one third of the patients "failed to learn their diagnoses at all."

Drs. Reader, Seligmann and Pratt said that "patients exhibited a remarkable vagueness and uncertainty about what would happen to them in the course of their visits to the physicians."

The patients' conceptions of a good doctor, the study indicated, "showed an almost even split between attributes that related to medical competence and those that related to the skill of the physician in handling interpersonal relationships.

"In describing a poor doctor, the patients placed considerable emphasis on his failure to get results, that is, results in terms of the patients' expectations. An unfriendly, disinterested attitude was stressed almost equally as a characteristic of poor doctors."

Mississippi Institute

JACKSON, MISS.—The new University of Mississippi Medical Center will be the scene of an institute on hospital housekeeping January 22 to 24, sponsored by the Southeastern Hospital Conference, Mississippi Hospital Association and the University of Mississippi.

Hanner New President of Arizona Association

PHOENIX, ARIZ.—Guy M. Hanner, administrator of Good Samaritan Hospital, Phoenix, was elected president of the Arizona Hospital Association at the group's annual convention here.

Other officers are vice president, James L. Cline, administrator, Gila General Hospital, Globe, and secretary-treasurer, Florence L. Ladner, administrator, Hoemako Co-operative Hospital, Casa Grande.

Aldridge President-Elect of Nebraska Association

OMAHA, NEB.—Gerald L. Aldridge, administrator of Mary Lanning Memorial Hospital, Hastings, was named president-elect of the Nebraska Hospital Association at its 20th annual convention here.

Other officers are president, Duane E. Johnson, administrator, University of Nebraska Hospital, Omaha; vice president, Sister Mary Kevin, director of the school of nursing, St. Catherine's Hospital, Omaha; treasurer, Sister Mary Gertrude, administrator, St. Mary's Hospital, Columbus, and secretary, Eugene C. Edwards, administrator, Bryan Memorial Hospital, Lincoln.

COMING EVENTS

ALABAMA HOSPITAL ASSOCIATION, Whitley Hotel, Montgomery, Jan. 24, 25.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Schroeder Hotel, Milwaukee, Oct. 7-10.

AMERICAN COLLEGE OF OSTEOPATHIC HOSPITAL ADMINISTRATORS, St. Louis, Oct. 26.

AMERICAN HOSPITAL ASSOCIATION, Midyear Conference for Presidents and Secretaries of State Hospital Associations, Palmer House, Chicago, Feb. 4, 5. National convention, Convention Hall, Atlantic City, N.J., Sept. 30-Oct. 3.

AMERICAN MEDICAL ASSOCIATION, Congress on Medical Education and Licensure, Palmer House, Chicago, Feb. 10-12.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, St. Louis, Oct. 27-30.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Palmer House, Chicago, Feb. 27-Mar. 1.

AMERICAN SOCIETY OF MEDICAL TECHNOLOGISTS, Palmer House, Chicago, June 22-29.

AMERICAN SOCIETY OF X-RAY TECHNICIANS, international convention, Sheraton Park Hotel, Washington, D.C., June 8-13.

ASSOCIATION OF MILITARY SURGEONS OF THE UNITED STATES, Hotel Statler, Washington, D.C., Oct. 28-30.

ASSOCIATION OF OPERATING ROOM NURSES, Hotel Statler, Los Angeles, Feb. 18-20.

ASSOCIATION OF WESTERN HOSPITALS, Statler Hotel, Los Angeles, May 6-9.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Hotel Roanoke, Roanoke, Va., April 4, 5.

CATHOLIC HOSPITAL ASSOCIATION, Statler Hotel, Cleveland, May 27-30.

CONFERENCE OF CATHOLIC SCHOOLS OF NURSING, 10th annual meeting, Statler Hotel, Cleveland, May 25-26.

HOSPITAL ASSOCIATION OF PENNSYLVANIA, Convention Hall, Atlantic City, N.J., May 22-24.

KENTUCKY HOSPITAL ASSOCIATION, Phoenix Hotel, Lexington, Mar. 26-28.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Hotel Shoreham, Washington, D.C., Nov. 18-20.

MASSACHUSETTS HOSPITAL ASSOCIATION, Hotel Statler, Boston, May 9.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N.J., May 22-24.

MID-WEST HOSPITAL ASSOCIATION, Hotel President, Kansas City, Mo., April 24-26.

NATIONAL ASSOCIATION FOR PRACTICAL NURSE EDUCATION, Ambassador Hotel, Atlantic City, N.J., April 29-May 3.

NATIONAL ASSOCIATION OF METHODIST HOSPITALS AND HOMES, Palmer House, Chicago, Feb. 26-28.

NEW ENGLAND HOSPITAL ASSEMBLY, Statler Hotel, Boston, Mar. 25-27.

NEW MEXICO HOSPITAL ASSOCIATION, Hilton Hotel, Albuquerque, Mar. 11-13.

OHIO HOSPITAL ASSOCIATION, Hotel Cleveland, Cleveland, Mar. 31-April 4.

SOUTH CAROLINA HOSPITAL ASSOCIATION, Wade Hampton Hotel, Columbia, Jan. 18.

SOUTH DAKOTA HOSPITAL ASSOCIATION, spring conference, Marvin Hughitt Hotel, Huron, April 15-16; fall meeting, Sheraton Cataract Hotel, Sioux Falls, Oct. 15-16.

SOUTHEASTERN HOSPITAL CONFERENCE, Atlanta Biltmore Hotel, Atlanta, Ga., April 24-26.

TENNESSEE HOSPITAL ASSOCIATION, Mountain View Hotel, Gatlinburg, May 30-June 1.

TEXAS HOSPITAL ASSOCIATION, Shamrock-Hilton Hotel, Houston, May 14-16.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, April 29-May 2.

UPPER MIDWEST HOSPITAL CONFERENCE, Auditorium, Minneapolis, May 22-24.

VIRGINIA HOSPITAL ASSOCIATION, Hotel Chamberlin, Old Point Comfort, Nov. 15-16.

WEST VIRGINIA HOSPITAL ASSOCIATION, Greenbrier Hotel, White Sulphur Springs, Aug. 1-3.

Nursing Officials Report 28,000 More Nurses Now

NEW YORK CITY. — About 28,000 more professional nurses are at work today in the United States than there were two years ago, according to information pooled by three organizations—American Nurses' Association, National League for Nursing, and the U.S. Public Health Service.

However, an additional 70,000 nurses are needed to reach the reasonable goal of 300 professional nurses per 100,000 population.

An estimated 430,000 professional nurses were employed in January 1956, compared with 401,600 in January 1954, an increase of 3 per cent in the ratio of nurses to population. In 1954 there were 251 nurses per 100,000 population and this year there were 259.

Doctor Denies Mental Hospitals Are "Dumping Grounds" for Oldsters

WASHINGTON, D.C.—Mental hospitals are not a "dumping ground for the aged whose relatives don't want to be bothered with them," the medical consultant for the National Association for Mental Health said last month.

Dr. George S. Stevenson called "the common belief that our mental hospitals are filled with old folks who have nothing wrong with them" a "gross exaggeration." Dr. Stevenson was speaking at the convention of the N.A.M.H. here.

He based his statements on a 40 year statistical study of the New York mental hospitals, made by Dr. Benjamin Nalzberg. The study will be published in several installments in the quarterly magazine, *Mental Health,* of which Dr. Stevenson is the editor.

Although the greatest incidence of schizophrenia is between the ages of 20 and 35 and accounts for most of the hospitalized mental cases, "those who do not recover after treatment generally linger on as custodial patients for five, 10, 15 and even as long as 30 or 40 years after admission," Dr. Stevenson said.

"That is why today schizophrenic patients make up so large a proportion —about 50 per cent—of the total mental hospital population. They enter as young patients, and become chronic old patients," he added.

Cerebral arteriosclerosis and senile psychosis, both of which appear after the age of 60, are second and third in order of volume of occurrence, Dr. Stevenson reported. While these two diseases make up about 35 per cent of all new mental hospital admissions each year, they do not keep this high proportion very long, he said, since more than half of them are dead within one year after admission.

Kansas Group Names Evans President-Elect

HUTCHINSON, KAN.—Austin J. Evans, administrator of Hadley Memorial Hospital, Hays, Kan., was named president-elect of the Kansas Hospital Association at its 42d annual convention here.

Other officers are president, Roger B. Samuelson, Susan B. Allen Memorial Hospital, Eldorado; vice president, Sister M. Roberta, St. Elizabeth's Mercy Hospital, Hutchinson, and treasurer, Fred M. Walters, Atchison, Topeka and Santa Fe Hospital, Topeka.

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ABOUT PEOPLE

(*Continued From Page 76*)

Leo D. Carsner

Leo D. Carsner has assumed the duties of administrative assistant at Highland View Hospital, Cleveland. Mr. Carsner received his master's degree in hospital administration from Northwestern University. He served his administrative residency at Newton Wellesley Hospital, Newton Lower Falls, Mass.

Carl R. Baum, controller at Children's Hospital of Philadelphia, has been appointed assistant director of the hospital. He succeeds **Donald L. Ford,** who resigned to accept a similar position at St. Joseph's Hospital, Lexington, Ky.

Dr. Richard Ahrens, superintendent of Kentucky State Hospital, Danville, Ky., for the last six years, has resigned the post because of poor health. Dr. Ahrens received his medical education at the University of Minnesota and has been a psychiatrist and mental hospital administrator throughout his professional career.

Sister Rene has succeeded **Sister Scholastica** as administrator of City Hospital, Mobile, Ala.

Sister M. Philaberta, has been appointed administrator of St. Margaret's Hospital, Kansas City, Kan. Formerly administrator of St. Mary's Hospital, Cincinnati, Sister Philaberta succeeds **Sister M. Cordula,** who has been recalled to the provincial house.

Paul K. Potter has been named administrator of Daviess County Hospital, Washington, Ind. He formerly was administrative assistant at Wesley Hospital, Wichita, Kan., and served his administrative residency at Methodist Hospital, Indianapolis.

Sister Philip Maria is the new administrator at Holy Family Hospital, Ensley, Ala. She succeeds **Sister Alice Martha.**

Sister M. Leonarda has been appointed administrator of St. Edward's Hospital, New Albany, Ind.

Harold C. Mufson

Harold C. Mufson has been appointed administrative assistant at Long Island Jewish Hospital, New Hyde Park, Long Island, N.Y. His primary assignment is to coordinate a methods improvement research project being conducted jointly by the hospital and the United Hospital Fund. Mr. Mufson has a master's degree in hospital administration from Catholic University of America and served his administrative residency at Beth Israel Hospital, Boston.

Robert L. Jensen has accepted the position of administrator of Arenac General Hospital, Omer, Mich. He has been superintendent of Thayer County Memorial Hospital, Hebron, Neb., since July 1956. His successor at Thayer is Robert Hill who was formerly associated with St. Francis Hospital, Grand Island, Neb.

Elton W. Barclay is the new administrator of Stetson Hospital, Philadelphia.

Dr. Samuel W. Friedman has become assistant to the executive vice president of the Albert Einstein Medical Center, Philadelphia. **Dr. J. A. Rosenkrantz** succeeds Dr. Friedman as administrator of the center's southern division.

Dr. Leon Ross, director of profes-

sional services at the Veterans Administration Hospital, Cleveland, has been appointed manager of the Veterans Administration Hospital at Brecksville, Ohio. Dr. Ross will succeed **Dr. Willard L. Quennell,** who has been transferred to the V.A. regional office in Detroit. Dr. Ross has been with the V.A. since 1942. He has served in hospitals in Pennsylvania, Missouri and Kentucky.

Dr. Albert T. Hume, director of professional services at the Veterans Administration Center, Temple, Tex., has been appointed manager of the Veterans Administration Hospital, Outwood, Ky. He succeeds **Dr. Otis N. Shelton,** who will become manager of the Veterans Administration Hospital, Kerrville, Tex. The Kerrville position has been vacant since the death of **Dr. Judd H. Kirkham** in September.

George M. Stockbridge, administrator of Wilkes General Hospital, North Wilkesboro, N.C., has been named administrator of Cape Fear Valley Hospital, Fayetteville, N.C. Mr. Stockbridge's successor in North Wilkesboro will be **M. E. Bullard,** who presently is administrator of Pender Memorial Hospital, Burgaw, N.C.

J. A. Fraser, assistant director of the Royal Victoria Hospital, Montreal, Quebec, since 1947, has retired after 38 years of service.

Dr. Granville L. Jones, superintendent of Eastern State Hospital, Williamsburg, Va., since 1946, has resigned to accept a similar position at the Arkansas State Hospital, Little Rock.

Robert D. Southwick has been appointed administrator of Children's Hospital, Cincinnati.

True Taylor is the new administrator for Jefferson Memorial Hospital, Festus, Mo., which is now under construction. Mr. Taylor formerly was administrator of Bethesda General Hospital, St. Louis.

Homer E. Catledge has been named administrator of Ivy Memorial Hospital, West Point, Miss., succeeding **Jesse H. Bartlett.**

Mary Jane Swartzendruber, an instructor in the school of nursing at Mennonite Hospital and Sanitarium, La Junta, Colo., has been named superintendent of Greeley County Hospital, Tribune, Kan. She succeeds **Delmar B. Bottoroff.** Miss Swartzendruber served as superintendent of Greeley County Hospital before accepting the position in La Junta.

Sister Mary Adolpha has been named administrator of St. Mary's Hospital, Enid, Okla., succeeding **Sister M. Lucille** who has moved to the mother house in Wichita, Kan. Sister Lucille will act as adviser for the new St. Francis Hospital to be built in Tulsa, Okla.

Sister Mary Antonia has been appointed administrator of St. Joseph's Hospital, Tacoma, Wash. She succeeds **Sister Mary Valeria.** Sister Antonia formerly was administrator of St. Joseph Hospital, La Grande, Ore.

A. William Smith is the new administrator of Mark E. Reed Memorial Hospital, McCleary, Wash., succeeding **Richard M. Davert.**

Department Heads

Ellen D. Howland

Ellen D. Howland has been appointed director of nursing at New England Deaconess Hospital, Boston, succeeding **Mildred B. Newton.** Miss Howland will head the school of nursing as well as the hospital's nursing service. For the last five years she has served as assistant director of the school of nursing. At the same time it was an-

nounced that **Joan Randle** has been appointed assistant director of the school of nursing and **Janie G. Christie** has been named supervisor of clinical instruction.

Robert J. Moore has been named business manager of Long Beach Memorial Hospital, Long Beach, N.Y. He succeeds **Mrs. Dorothy Tucker,** who resigned.

Miscellaneous

A. C. Eglin Jr. has been appointed controller of Jefferson Medical College and Hospital, Philadelphia. He formerly was assistant director of the Hospital Council of Philadelphia.

W. G. Ebersole

W. Glenn Ebersole, director of hospital and professional relations for the Southern California Blue Cross Plan, has been named executive director of the Hospital Council of Southern California. The council is a cooperative association of 108 Southland hospitals which engages in cooperative research and educational activities aimed at improving hospital care. Mr. Ebersole has been active in hospital and medical fields for nearly 20 years, helped found the California Physicians' Service in 1939, and has been public relations director of the California Medical Association.

Charles Roswell, hospital accounting consultant who was formerly on the staff of the United Hospital Fund, has returned to the Fund as director of hospital services, succeeding **Dr. Hugo V. Hullerman,** who has resigned. Dr. Hullerman was formerly secretary of the Council on Professional Practice of the American Hospital Association.

Deaths

Dr. Hursel C. Manaugh, manager of the Veterans Administration Hospital, Fayetteville, Ark., died November 24 following a heart attack. He was 56.

Ben E. Cole, vice president and secretary of Doctors Hospital, Inc., New York, died November 24. He was 63. Mr. Cole was born in Philadelphia and received a degree in mechanical engineering from Lehigh University in 1913.

Dr. Oscar Jacobson, 50, president of the Northeastern Society of Orthodontists, died November 25 in New York. Dr. Jacobson was chief of the orthodontic department of Midtown Hospital, consultant on orthodontics for Jewish Chronic Disease Hospital, Brooklyn, N.Y., and New York city-wide chairman of the dental division of the United Jewish Appeal.

CORRECTION

In reporting that **Horace V. Snyder** was appointed administrator of Sudbury Memorial Hospital, Sudbury, Ont., the name of the hospital was erroneously given as Sudbury General Hospital in the November issue of The Modern Hospital.

Merged Nursing Home Group Elects Wallace

HOUSTON, TEX.—Ira O. Wallace of New Castle Sanitarium, New Castle, Ky., was elected president of the American Nursing Home Association at its convention here.

Other officers include first vice president, Alton Barlow, Canton Nursing Home, Canton, N.Y.; secretary, J. T. Wheeler, Matthews, N.C., and treasurer, Morrill S. Ring, Ring's Nursing Home, Medford, Mass.

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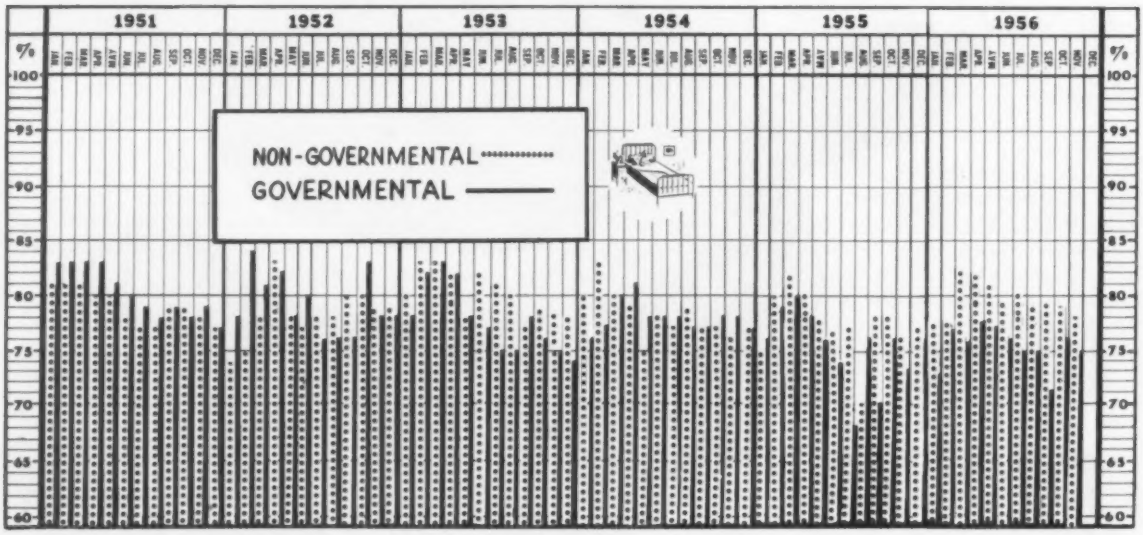
Voluntary Hospital Occupancy Shows Slight Decrease



Reports to the Occupancy Chart for the month of November 1956 showed government hospitals at 74.7 per cent of capacity and voluntary hospitals at 77.9 per cent of capacity, compared to 74.7 and 78.7 per cent last year.

For the period November 12 through December 10, construction amounted to $64,152,970, bringing the 1956 building total to $967,889,691. For the comparable period of 1955, construction totaled $75,794,530, aggregating $711,209,570 for the year. Of the 75 current projects, 20 are hospitals, 48 are additions to existing facilities, five are alteration projects, one is a nurses' home, and one, an addition to a nurses' home.

At Indiana University's Medical Center Union ... Libbey Heat-Treated Glassware gives long, economical service

An interior view of the dining room, seating over 350.

The Governor Clinton pattern is used in the Indiana University Medical Center Union Dining Room and Snack Bar. Pictured is No. 610, 9½ oz. Heat-Treated Water Tumbler.

At the beautiful new Indiana University Medical Center Union, Indianapolis, Indiana, Libbey Heat-Treated Glassware is used for dining room and snack bar service. This attractive glassware gives extra long life and operating economy . . . economy assured by Libbey's guarantee: "A new glass if the rim of a Libbey 'Safedge' ever chips."

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Libbey's Heat-Treated Governor Clinton pattern complements these attractive rooms . . . and of course, gives long service under the severest conditions. These Heat-Treated Tumblers are specially processed to withstand rough treatment and high sterilization temperatures . . . reduce breakage, require fewer replacements, and thus keep necessary inventory at a minimum.

In the finest hotels and restaurants across the country, Libbey Glassware gives many operating advantages. Whether your operation is large or small you can afford the benefits of this fine Libbey service. See your Libbey Supply dealer, or write Libbey Glass, Division of Owens-Illinois, Toledo 1, Ohio.

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The names of these leading restaurants and hotels, and full details of their own surveys, will be supplied on request.

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POSITIONS WANTED

ADMINISTRATOR—8 years, 250-bed general hospital; chief accountant, administrative assistant, 4 years assistant; experience includes planning, equipping, staffing new hospital; NACHA-34. Apply MW 129, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

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ADMINISTRATOR—B.S. (Business Administration) M.H.A.; years residency, 700-bed hospital; 1 year, assistant administrator, 2 years, administration, same 500-bed hospital; active in hospital affairs; early 30's; any locality; nominee ACHA.

ADMINISTRATOR—R.N., male; B.S. (Business Administration) 6 years, assistant administrator, 375-bed, university affiliated hospital; seeks hospital 100-beds up; references unit in excellent commendations; member ACHA.

ASSISTANT ADMINISTRATOR—M.S. (Hospital Administration); university hospital; currently administrative assistant, 600-bed hospital; seeks assistantship, hospital 400-beds up; any locality; early 30's.

ASSISTANT ADMINISTRATOR—R.N., B.S., M.H.A., 6 years private duty, 5 years charge nurse and supervisor, Army hospitals; 2 years, director of nurses, large hospital; well prepared for and interested in hospital administration; prefer southwest; medium size hospital.

ANESTHESIOLOGIST — M.S. (Anesthesiology); currently, chief, one of America's finest teaching groups, very large size; outstanding specialist, nationally known; seeks chiefship, larger hospital, south or westcoast; Diplomate; FACA; highest references.

PATHOLOGIST—7 years, chief, pathology, 450-bed, teaching hospital; Diplomate, C.P., P.A.; F.C.A.P.; any locality.

PATHOLOGIST—Diplomate, anatomy; qualified C.P.; 32; 4 years experience, pathology as chief, 300-bed hospital and director, pathological laboratory, large city; prefers percentage arrangement; west, midwest.

PURCHASING DIRECTOR—3 years assistant purchasing director; 3 years, purchasing director, university hospital; only hospitals, 400-beds up; middle 30's; member PAA.

RADIOLOGIST—Mayo trained; M.S., (Radiology); 4 years, chief, 600-bed medical school affiliated hospital; Diplomate, both branches, isotopes.

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ADMINISTRATOR—Medical; four years, assistant director, 800-bed university hospital; eight years, administrator, 400-bed teaching hospital.

ADMINISTRATOR—M.H.A. (Hospital Administration); four years, associate director, teaching hospital, assisting in building program increasing capacity from 200 to 400; five years, director, 225-bed hospital.

ASSISTANT ADMINISTRATOR—B.A., Business Administration; Master's, Hospital Administration; following residency, 350-bed hospital, remained as Purchasing Agent, later as Director of Methods Improvement.

DIRECTOR OF NURSING—M.S. (Nursing Service Administration); four years, assistant director, nursing service, 300-bed hospital.

FOOD SUPERVISOR—B.S. (Major: Hotel and Restaurant Management); excellent experience.

PATHOLOGIST—Director of pathology, 400-bed general hospital since 1948; interested teaching; established approved school of medical technology; held in high esteem by medical staff.

RADIOLOGIST—University hospital training in radiology; graduate training, isotopes; six years director department, 250-bed hospital; Diplomate.

SOCIAL WORKER—B.A., M.S.W.; five years, consultant, state department of social welfare.

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ASSISTANT ADMINISTRATOR—Age, 32 years; graduate University of Pennsylvania; Major, Commerce; M.H.A. Degree, 1955. 2 years experience, 75-bed hospital.

ADMINISTRATOR—M.A. Degree, mid-western university; M.H.A. Degree, 1950; administrative assistant, large Colorado hospital; 5 years experience, 120-bed hospital; completed new addition; desires change.

BUSINESS MANAGER—Clinic or small hospital; prefers west, or south; experienced accountant; 10 years business manager, two small hospital-clinics.

ADMINISTRATOR—B.S. Degree, Business Administration; 10 years personnel supervisor, large firm, east. 4 years administrator, small western hospital.

EXECUTIVE HOUSEKEEPER—14 years hotel housekeeper; 4 years executive housekeeper, 125-bed eastern hospital; will consider east or mid-west.

(Continued on page 186)

INTERSTATE—*Continued*

DIRECTOR OF NURSING—B.S. Degree, Northwestern University; 20 years experience, outstanding hospitals, mid-west and south; available spring 1957.

POSITIONS OPEN

ADMINISTRATOR or BUSINESS MANAGER—Experience necessary, salary open; 50-bed general hospital; Milwaukee aren. Apply MO 159, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

ANESTHETIST—Registered nurse; 50-bed new modern hospital; pleasant working conditions, good personnel policies; adequate provision for week-ends and days off; two weeks paid vacation at end of year; salary open. Apply MO 162, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

ANESTHESIOLOGIST—Board eligible; wanted immediately; to join a group of 6 staff anesthesiologists. If available write or phone Stevens J. Martin, M.D., Director Department of Anesthesiology, St. Francis Hospital, Hartford 5, Connecticut.

ANESTHETIST—Nurse; for obstetrics or surgery, salary open, three weeks vacation the first year, 12 days sick leave per year, accumulative. Apply to Personnel Director, Methodist Hospital, 1600 West 6th Avenue, Gary, Indiana.

ANESTHETIST—Nurse; excellent working condition; $400.00 per month with annual increases of $25.00 per month to maximum of $500.00; two weeks vacation, after one year, three weeks after five years, minimum of two weeks sick leave; usual employee benefits; Lexington is located in "The Heart of the Bluegrass" famous for horse racing and tobacco industries, home of University of Kentucky and Transylvania College. Apply, Assistant Administrator, Good Samaritan Hospital, South Limestone Street, Lexington, Kentucky.

ANESTHETIST—Nurse; to join obstetrical anesthesia staff; 40 hour week; salary adjusted to experience. Write Administrator, Highland Hospital, Rochester, New York.

ASSISTANT ADMINISTRATOR — For large municipal hospital; we are seeking the services of an individual with a master's degree or its equivalent plus two years of experience in hospital administration including one year in an administrative capacity in a large institution; the beginning salary is $6480; maximum of $8140, in five years; an upward revision is expected in 1957; many substantial fringe benefits in addition. Contact Mr. M. Rodzenko, Administrator, Philadelphia General Hospital, 34th Street and Curie Avenue, Philadelphia 4, Pennsylvania.

ASSISTANT DIRECTOR OF NURSING SERVICE—650-bed general hospital located in industrial city (300,000); primary responsibility to plan and supervise in-service program; experience and preparation in nursing service administration desirable. Write Director of Nursing, Miami Valley Hospital, Dayton 9, Ohio.

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POSITIONS OPEN

ASSOCIATE DIRECTOR OF NURSING—650-bed general hospital located in industrial city (300,000 population); all new facilities, hospital opened in 1954; experience required; Masters degree in Nursing Service Administration preferred. Write Director of Nursing, Miami Valley Hospital, Dayton 9, Ohio.

DIETITIAN—Modern kitchen, 74 employees, liberal food budget, 600-bed fully accredited hospital; no nursing school; social security and State retirement; salary range $3,588-$4,428; liberal annual and sick leave privileges; member A.D.A. preferred. Apply MO 169, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIETITIAN—Chief; 120-beds; no school of nursing; salary $425 up; full supervision kitchen and therapeutics. Apply Jane S. Davis, Pawating Hospital, Niles, Michigan.

DIETITIAN—Immediate opening at 200-bed general hospital in the Detroit area, for qualified Dietitian; ADA membership preferred; starting salary $5369; excellent employment benefits. Contact Administrative Dietitian, Pontiac General Hospital, Pontiac, Michigan.

DIETITIANS—Therapeutic dietitians; Barnes Hospital, large teaching hospital; 6 units affiliated with Washington University School of Medicine; beginning salary $325 per month; social security. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—Assistants; food production or therapeutic; Teaching Hospital. Apply to Director, Department of Nutrition and Dietetics, University of Missouri, 807 Stadium Road, Columbia, Missouri.

DIETITIAN—A.D.A.; to head department; 140-bed general hospital, 35 miles from New York City; duties include therapeutic diet planning, patient contact, general supervising, teaching student nurses; salary open; maintenance available. Apply Director, Middlesex General Hospital, New Brunswick, New Jersey.

DIETITIANS—Therapeutic and assistant cafeteria manager for research hospital; A.D.A.; housing aid available for finding apartment; liberal benefits; 5 days. Please send resume and salary requirement to Personnel Department, Memorial Center, 444 East 68th Street, New York 22, New York.

DIETITIAN—Staff; therapeutic A.D.A. member to supervise tray service and related employees and patient contact for hospital completing expansion to 500-beds; entirely new department; dietetic program integrated with approved school of nursing; affiliated with medical research institute sick leave, social security, hospitalization insurance, 40 hour week, 2 weeks vacation, 6 holidays, etc. Contact Miss Rosemary Brown, Dietitian Director, Toledo Hospital, Toledo 6, Ohio, or telephone collect to Lawnsale 1121.

DIETITIAN—Therapeutic, assistant to chief; for a 306-bed teaching hospital with diagnostic clinic; a large full-time medical staff and house staff, salary open, progressive personnel policies. Apply Chief Dietitian, Geisinger Memorial Hospital and Foss Clinic, Danville, Pennsylvania.

DIETITIAN — Administrative, assistant to chief; for a 306-bed teaching hospital with diagnostic clinic; a large full-time medical staff and house staff, salary open, progressive personnel policies. Apply Chief Dietitian, Geisinger Memorial Hospital and Foss Clinic, Danville, Pennsylvania.

DIETITIAN — A.D.A.; therapeutic; 160-bed general hospital, college town, 20 miles west of Milwaukee; major expansion program to be started in spring of 1957; modern dietary department completely remodelled in 1954-55. Apply Personnel Department, Waukesha Memorial Hospital, Waukesha, Wisconsin.

DIRECTOR OF DIETETICS—In a 450-bed voluntary teaching general hospital; experience required preferably in large institution with large diabetic service and employees' cafeteria; medical staff made up of specialists in the city; school of nursing with over 200 students; active house staff program; staff of 8 dietitians; salary open. Apply Administrator, Good Samaritan Hospital, Portland 10, Oregon.

DIRECTOR OF NURSES — 100-bed hospital now being enlarged to 180-beds; adequate training and experience required; salary open. Apply Administrator, Municipal Hospital, Virginia, Minnesota.

DIRECTOR OF NURSING — For a 2700-bed state psychiatric hospital, beautiful location; director is responsible for the affiliate school and for nursing service; Degree in nursing education plus administrative and teaching experience required; retirement plan, 40-hour week. For further information write Superintendent. Danville State Hospital, Danville, Pennsylvania.

DIRECTOR OF NURSING SERVICE—64-bed general modern hospital, mild southern climate, northern Alabama; because of increased activity, well-qualified person needed; salary commensurate with experience and ability; paid vacation, holidays, sick leave, social security. Apply Thos. L. Qualey, Administrator, Athens-Limestone Hospital, Athens, Alabama.

DIRECTOR OF NURSING SERVICES—For 124-bed general hospital soon to be expanded; salary about $5000.00 depending upon experience; located in a growing New York City suburb, adjacent to resort area. Contact Administrator R.M. Drumm, Nyack Hospital, Nyack, New York.

INSTRUCTOR IN CLINICAL NURSING—For diploma school of nursing of approximately 90 students; good personnel policies; 40 hour week; experience in teaching and degree in nursing education preferred; starting salary $400. Apply MO 165. The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

INSTRUCTOR — Clinical in obstetrics for diploma school of nursing; newly modernized obstetrical unit; 75 miles from New York City; good personnel policies, 40 hour week; experience in teaching obstetrics and degree in nursing education preferred; starting salary $400. Apply MO 164, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

INSTRUCTOR—Clinical operating room; newly modernized operating room; 268-bed hospital; 1½ hours from New York City; diploma school; 40 hour week; good personnel policies; experience in operating room teaching and degree in nursing education preferred; starting salary $400. Apply MO 166, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

INSTRUCTOR—Pediatric clinical; for diploma school of nursing; pediatric unit approximately 20-beds; 1½ hours from New York City; 40 hour week; good personnel policies; experience in teaching in pediatrics and degree in nursing education preferred; starting salary $400. Apply MO 167, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

(Continued on page 188)

INSTRUCTOR—Science; for diploma school of nursing; approximately 90 students; 75 miles from New York City; 40 hour week; good personnel policies; experience in teaching in science and degree in nursing education preferred; starting salary $400. Apply MO 168, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

INSTRUCTOR—Clinical; operating room technique, 200-bed hospital; 40 hour week, 4 week-vacation. For further information write Director of Nursing, Iowa Lutheran Hospital, Des Moines.

INSTRUCTOR—Pediatric; who knows what pediatrics really is, and how to interpret it to student nurses; superior working conditions, freedom to use personal initiative and imagination, cooperative co-workers and associates in outstanding Children's Hospital of friendly Kentucky Derby City; salary entirely dependent upon preparation and experience; this is an unusual opportunity for an alert, ambitious nurse who would enjoy doing creative work in a happy atmosphere. For details write Director of Nursing, Children's Hospital, Louisville, Ky.

INSTRUCTOR—Clinical pediatric nursing; Degree and experience in nursing of children required; school of nursing fully accredited; 650-bed non-profit hospital located in industrial city (population 300,000); 40 hour week; paid vacations; liberal benefits. Write Director of Nursing, Miami Valley Hospital, Dayton 9, Ohio.

INSTRUCTOR — Clinical Pediatrics; 265-bed general hospital, pediatrics daily average 30; school enrollment 130; degree or working toward degree; experience; salary open, policies liberal. Apply Director of Nurses, St. Joseph's Hospital, Lancaster, Penna.

INSTRUCTOR FOR NURSES' AIDES—General hospital treating men, women and children; 128 adult and pediatric beds plus 24 bassinets; 40 hour week; salary open. Apply Director, Woman's Hospital, 1940 East 101st Street, Cleveland 6, Ohio.

LIBRARIAN—Registered record; for new 300-bed hospital; full charge in setting up new installation; located 30 minutes from New York City. Write stating education and experience. MO 170, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

LIBRARIAN — Record; to supervise medical record departments of two general hospitals; 186-beds and 106-beds; 15 miles apart connected by new super highway; resort area year around; college town; minimum salary $400.00 per month. Write Administrator at St. Luke's Hospital, Marquette, Michigan or Francis A. Bell Memorial Hospital, Ishpeming, Michigan.

LIBRARIAN—Medical record; registered to assume charge of record room; 135-bed general hospital; 40 hours; salary open. Contact Miss G. A. Cooper, Woman's Hospital, Cleveland 6, Ohio.

LIBRARIAN—Registered medical records; To head department; also, opening for assistant to chief of department, in accredited hospital of 296-beds and 36 bassinets; 40 hour week and salary open. Apply to Administrator, The Williamsport Hospital, Williamsport, Pennsylvania.

LIBRARIAN—Medical record; required immediately as assistant; R.R.L. preferred; excellent personnel policies; health benefits available; Apply stating experience and salary desired to Personnel Director, Sarnia General Hospital, Sarnia, Ontario.

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MISCELLANEOUS—Oregon seeks board certified or board eligible Psychiatrists and Internists; vacancies now exist at 3500-bed Mental Hospital approved for two year psychiatric residency; applicants must be eligible for Oregon licensure; salary $9300 to $11,800 depending on qualifications; excellent housing with full maintenance for staff and family is provided at cost of $85 a month. For details write D. K. Brooks, M.D., Superintendent, Oregon State Hospital, Salem, Oregon.

MISCELLANEOUS — Assistant Director and General Duty Nurses for Grace Dart Hospital, 6085 Sherbrooke Street, East, Montreal, Quebec. Apply to Director of Nursing.

NURSES—General duty for 306-bed general hospital; serving community of 100,000; starting salary $275 per month plus meals and laundry; bonus of $25 for evening and night shifts; increment of $5.00 every six months for a period of four years; hospital twenty miles from New York City on Long Island Sound; train service every half hour. Apply Director of Nursing, New Rochelle Hospital, New Rochelle, New York.

NURSE—General duty; for 17-bed hospital; starting salary $200 gross; 1 month vacation with pay after 1 year service, $5.00 per month increase after each 6 month service up to 3 increases; transportation refunded after 6 month service. Apply Municipal Hospital, Elnora, Alberta.

NURSES—Operating room and staff; for 227-bed pediatric hospital in sunny California; salary $300 per month with differential for operating room and evening and night duty; 5 day, 40 hour week; liberal personnel policies including vacation, sick time and retirement. Apply Director of Nursing, Childrens Hospital Society, 4614 Sunset Blvd., Los Angeles 27, California.

NURSES—Operating room; for teaching hospital within walking distance of teachers college; salaries and personnel policies comparable to other hospitals in area. Write Director of Nursing, Box P, St. Luke's Hospital, New York 25, New York.

NURSE—Operating room; for modern air-conditioned, two room suite, in 52-bed general hospital; 12 days sick leave, 2 weeks vacation annually, paid holidays, annual bonus, 40-hour week; salary open. Apply Director of Nurses, Parkview Hospital, 1920 Parkwood Avenue, Toledo 2, Ohio.

NURSES—Psychiatric; for supervising psychiatric buildings and attendants; mature, experienced; $3,000 per year, board, room and laundry available at $480 per year; social security and pension. Send full information to Director of Nurses, Brattleboro Retreat, Brattleboro, Vermont.

NURSE — Registered; interested in teaching practical nursing; opportunities to develop own program; school not approved at present; desire individual capable of developing program which will meet State approval; small town located in southeast Pennsylvania. Apply MO 144, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

NURSES—Registered; Massachusetts General Hospital, Boston, Massachusetts; excellent clinical facilities, opportunity for advancement and attendance at local colleges; liberal personnel policies. Apply Personnel Department A-10 for further details.

NURSES—Registered; staff positions in 400-bed, teaching hospital, 25 minutes from Times Square; salary $260-290 per month; 5 days, 40 hour week; 4 weeks vacation; 21 sick days; 7 holidays. Apply Personnel, The Brooklyn Hospital, 121 DeKalb Avenue, Brooklyn, New York.

NURSES—Registered; for modern psychiatric hospital in Greens Farms, Connecticut; 1 hour from New York; Hall-Brooke nurses have 8-hour duty, optional 5 or 6 day week, nicely furnished private rooms; excellent salary, 7 paid holidays annually, or equivalent; sick leave; vacation, minimum 2 weeks, maximum 4 weeks dependent on length of service; profit-sharing plan; psychiatric experience not necessary; registered or eligible in State of Connecticut. Apply Mary R. Walsh, R.N., Directress of Nursing, Hall-Brooke, Box 31, Greens Farms, Connecticut. Tel. Westport—Capital 7-5105.

NURSES—Registered; are you looking for something new? Staff and assistant head Nurse positions open in beautiful new University of Oregon Medical School Hospital located on hill overlooking Portland, Oregon; medical surgical, pediatric and psychiatric units; excellent opportunities for learning, both in clinical areas and on campus; staff members may take courses at reduced tuition rate ($3 per quarter hour) leading to baccalaureate or masters degrees at the nursing school on the campus; liberal personnel policies; the northwest is a wonderful place to live and work. Write to Director of Nursing Service for full information. U. of O. Medical School Hospital, 3181 S. W. Sam Jackson Park Road, Portland 1, Oregon.

NURSES—Registered operating room; 150-bed privately-owned hospital; 40 hour week, 2 weeks vacation, 5 holidays, pension plan, group life insurance, complete maintenance; salary open, additional pay for call. Contact Personnel, Southwestern General Hospital, El Paso, Texas.

NURSES—Registered; (2) for general duty in 18-bed hospital; salary $265 to $300 plus partial maintenance, sick leave and holidays. Write Superintendent, Beaver County Hospital, Milford, Utah.

NURSES—Registered; for general duty for 150-bed tuberculosis sanatorium in Bartlett, Alaska; starting salary $250 per month plus complete maintenance with a $10 raise each six months to a maximum base pay of $280; $10 extra for evening and night shift; 8 hour day, 40 hour week, 8 to 4, 4 to 12, 12 to 8 shifts; new modern nurses residence. Write to Director of Nurses, Seward Sanatorium, Bartlett, Alaska.

NURSES—Staff; for new expanding hospital on Florida's west coast; salaries and personnel policies compare favorably with those in this area; 40-hour week, 4 weeks vacation, no shift rotation; Florida registration required. Apply Supervisor Nursing Service, Manatee Memorial Hospital, Brandenton, Florida.

NURSES—Supervisory and staff; 50-bed, well equipped modern hospital; basic salaries, general staff, $270; supervisory $300; 40 hour week, differential for nights, call, special training or experience; located in Hiway 99 halfway Seattle and Vancouver, B.C.; scenic, sports, fishing and hunting. Apply Administrator, Memorial Hospital, Sedro Woolley, Washington.

PHYSICAL THERAPIST—Registered chief; (white) for new 300-bed general hospital completely air-conditioned; 5½ day week, liberal personnel policies, salary open. Apply MO 161, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

(Continued on page 190)

SUPERINTENDENT OF NURSES—150-bed general hospital; fully approved by Joint Commission on Accreditation; metropolitan area, northeast Ohio; suitable experience required, no training school; salary open. Apply MO 133, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

SUPERINTENDENT—For modern 26-bed hospital; must be a registered nurse or a capable nurse wishing to get into this field will be considered. For all details contact Fred Crawford, President, Renville Bottineau Memorial Hospital, Mohall, North Dakota.

SUPERVISOR—Operating room; 200-bed general hospital; experienced; 40 hour week, salary open. Apply Director of Nursing, Iowa Lutheran Hospital, Des Moines, Iowa.

TECHNOLOGIST—Medical registered 160-bed general hospital, college town, 20 miles west of Milwaukee, major expansion program including new department of laboratory medicine to be started in spring of 1957; affiliation with Carroll College for training of medical technologists now in development stage; full time pathologist. Apply Personnel Department, Waukesha Memorial Hospital, 725 American Avenue, Waukesha, Wisconsin.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

Telephone DElaware 7-1050

900 NORTH MICHIGAN AVENUE . CHICAGO

ADMINISTRATORS—(a) Voluntary general hospital; upon completion new addition, 500-beds; 3 assistants, 50 residents, interns; midwest. (b) Assistant medical administrator; hospital group; would direct 400-bed unit on own; midwest. (c) Medical consultant; important organization; some travel. (d) To succeed administrator retiring after 22 years; university city, west. (e) Voluntary general hospital, 160-beds; university city, midwest, $12,000. (f) General 60-bed hospital, construction to commence February; California. (g) General 50-bed hospital; building program; small town, near university city, east; $8000. (h) Hospital consultant; state health department; $7000-$8000; midwest. (i) Assistant administrator; Master's, 2 years experience required; new 300-bed general hospital, JCAH; foreign operations, large company; $9300 (Federal tax free), family maintenance. (j) Assistant; new 450-bed general hospital; affiliation university; south. (k) Assistant; 150-bed general hospital; California. (l) Assistant; university affiliated hospital, 350 beds; $7500-$8000; east. (m) Assistant; woman required; 250-bed hospital; lake suburb, leading university city; midwest, $6000. (n) RN; 10-bed American dispensary; China. MH1-1

ANESTHETISTS—(a) Percentage or salary; private medical center; excellent financial opportunity; Wisconsin resort area. (b) Industrial clinic; copper mining corporation; employee golf, tennis; foothills, Southwest mountain range; sole responsibility; $6000. (c) Staff; 5 under MD; air-conditioned operating room; 250-bed hospital; university city, south; $6600. (d) Staff; outside United States; fastest growing institution; English-speaking personnel; M.D. heads department; mild year round climate; tourist resort center. (e) 50-bed hospital; wealthy agricultural area near Omaha; $7200. MH1-2

DIETITIANS—(a) Chief; 250-bed voluntary general hospital; new cooperative administrator; college town, 20,000, Indiana; $6300. (b) Assistant food production manager; internationally acclaimed university hospital; share responsi-

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POSITIONS OPEN

MEDICAL BUREAU—*Continued*

bility; average 5000 meals daily; top salary; east. (c) Director, dietetics, 500-bed general hospital; direct all activities; new modern equipment; long range building program; large midwestern city; $6500 up. (d) see (c) under Executive Personnel. MH1-3

DIRECTORS OF NURSING—(a) Leading 400-bed university hospital, exceptional rating; excellent future opportunity; paid tuition to further education; key city; east; $8000. (b) Assistant director; leadership, initiative important; noted progressive 400-bed hospital; English-speaking personnel; interesting cosmopolitan city outside United States; $7000. (c) Director, school and service, 300-bed general hospital; well integrated school; university city, Pacific Northwest; $7200. (d) Male director, nursing service; large psychiatric institution; $7500; also assistant, $6350; vicinity Washington, D.C. MH1-4

EXECUTIVE HOUSEKEEPER—Direct 185-bed hospital; most congenial staff, working relations; attractive suburban community, Connecticut; salary commensurate qualifications. MH1-5

EXECUTIVE PERSONNEL—(a) Chief accountant; 325-bed general hospital; California. (b) Engineer, laundry manager, personnel director; new 350-bed general hospital; university city, south. (c) Accountant to serve as consultant; important organization; some travel. (d) Assistant chief engineer; general hospital, 450-beds; assume position chief within year; minimum $6000; university city, east. (e) Food service director; department staff, 54; general hospital, 275-beds; university city, southwest; $6000. (f) Personnel director; voluntary general hospital, 600-beds; vicinity New York City. (g) Purchasing director; 350-bed general hospital; college town, midwest. (h) Laundry manager; staff of 32; 550-bed general hospital; large city, Pennsylvania. MH1-6

FACULTY POSTS—(a) Director, nationally accredited school, 180 students; modern hotel-residence facilities; cultural university city; mild climate; top salary. (b) Fundamentals of nursing instructor, communicable disease; 300-bed hospital; American-owned oil company; foreign operations; excellent employee facilities; $8500-$9200 tax free, maintenance. (c) Assistant professor; class advisor; renowned university medical school; 130 students; ideal west coast location; $5000. (d) Psychiatric instructor, coordinate 2 schools, nursing with state college; academic rank; college personnel policies apply; ocean port; to $7200; south. MH1-7

RECORD LIBRARIANS—(a) Chief; well established hospital, 100-beds; university facilities nearby; gold, silver mining area; Alaska; $5500. (b) Chief; new university hospital, expanding to 450; progressive administrator; strong medical support; leading city, southwest; $6000. MH1-8

SUPERVISORS—(a) Take complete charge women's geriatric institution of 50; $300, full maintenance; city of 50,000, Pennsylvania mountain region. (b) Psychiatric; direct nurses, 55-bed private sanitarium; excellent opportunity, financial arrangement, Chicago. (c) Obstetric, with degree; outstanding 400-bed teaching hospital outside United States; large American Naval base; mild climate; to $5500; Pacific. (d) Volunteer services; complete administrative responsibility for hospital's entire program, recruitment, management; $4320; midwest. MH1-9

ADMINISTRATORS—(aa) 550-beds; fully approved, $18-20,000; midwest. (a) Medical; JCAH, voluntary hospital, 400-beds, large teaching program; to $22,000; midwest. (b) Fully approved large teaching hospital; one of finest in area; about $20,000; attractive college city, 185,000 midwest. (c) Voluntary JCAH teaching hospital, 260-beds; contemplate large building program; city 100,000; central. (d) 350-bed hospital; very desirable university town, 85,000; year round warm climate. (e) 200-bed hospital; Central America; staffed by American Diplomates. (f) 150-bed hospital; opportunity, $10,000. (g) Medical or non medical university hospital 700-beds; requires mature man, prefer FACHA. (h) 240-bed, JCAH hospital; Pacific coast.

ADMINISTRATORS—Women. (a) R.N. or non-medical; 3-year old, 60-bed general hospital; progressive community, 35 miles to important university center; midwest. (b) R.N. or non-medical; experienced public relations; general facility 75-beds; resort location; southeast. (c) R.N. or non-medical 60-bed general hospital open early 1957; residential city near well known university center; Pacific Coast. (d) R.N. or non-medical; eastern applicants only; approved general hospital 40-beds; $5-6000; lovely New England resort community.

ASSISTANT ADMINISTRATORS—(i) 800-bed teaching hospital; $7,500; large city; university medical center; mideast. (j) Direct volunteer services; teaching hospital, 800-beds; one of finest in south. (k) Report to medical director; 350-bed general hospital; $8,000; California. (l) JCAH, TB hospital, large size; California. (m) Voluntary hospital fairly large size; large town, vicinity Detroit. (n) 225-bed, voluntary hospital, teaching program; about $8,000; large city on Lake Michigan.

ADMINISTRATIVE ASSISTANTS—(o) 400-bed voluntary, teaching hospital; city, 500,000, midwest. (p) Prefer HA degree; qualified in accounting; California. (q) Two hospitals, 550-beds; attractive salary; town 250 000; university medical center; west. (r) 200-bed voluntary JCAH hospital; requires older man with minimum 5 years hospital experience; Washington, D.C. area. (s) 375-bed teaching hospital; prefer one with 2 years experience and HA degree; $9,000, annual increases; midwest. (t) General corporation hospital, 150-beds; New York city. (u) New 325-bed hospital; large city, south. (v) Young; degree HA; excellent opportunity to learn, advancement; California. (w) 250-bed JCHA voluntary hospital; near Chicago.

ANESTHETISTS—(a) Approved voluntary general hospital 100-beds; San Francisco Bay area. (b) By 2-man clinic group, operating 50-bed general hospital; $5400; small agricultural community; south central. (c) Long established 12-man clinic group, 150-bed affiliated hospital; to $6000; possibility of appointment as chief, higher salary; midwestern community 10,000. (d) Two; air-conditioned 7-room surgical suite; 300-bed general hospital; community 25,000 near important university center; east.

DIETITIANS—(a) Full charge of department, approved 100-bed general hospital; to $400; resort area, Pacific Northwest. (b) Chief; prefer knowledge therapeutic diets; voluntary general hospital 100-beds; Eastern capital city. (c) Chief; 250-bed general hospital, to occupy new facility shortly; to $5500; important southeastern university medical center.

(Continued on page 192)

WOODWARD—*Continued*

DIRECTOR OF NURSES—(a) Nursing service; approved voluntary general hospital 150-beds; $5000 minimum; university city, state capital; midwest. (b) Nursing service only; challenging opportunity for professional advancement; very large university hospital; supervise nearly 400 in nursing service; Southeastern university city. (c) Nursing service; newly opened, 120-bed general hospital; to $6000; California. (d) Nursing service and school of practical nursing; very large long term, general facility; residential community near New York City.

EDUCATIONAL DIRECTORS—(a) Well established school, 80 students now enrolled; fully approved 200-bed general hospital; to $7500; university city 300,000; midwest. (b) Assistant; excellent promotional potential; 200-250 students, approved school; to $5400; Pacific Northwest. (c) Associate to plan, execute curriculum; about 100 in approved school; 300-bed general hospital; $4200; resort city 20,000; east.

EXECUTIVE HOUSEKEEPERS—(a) New 325-bed facility now under construction to replace 100-bed institution; will be air-conditioned, superbly equipped; college city; ideal southern location. (b) Supervise department staff of 25; approved 200-bed general hospital; beautiful New England location near New York City. (c) to head department, 100-bed facility now under construction, to be completed late 1957; progressive community 50,000; resort, college location; midwest.

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ADMINISTRATOR—(a) 500-bed mid-western hospital; ideal situation. (b) 275-bed hospital, industrial center; expansion planned; experience and good record in public relations desired. (c) 150-bed mid-western hospital; new building; no school of nursing.

BUSINESS MANAGER—(a) 450-bed Ohio hospital; $7200. (b) 200-bed hospital, Pennsylvania. (c) Office manager-accountant; 175-bed eastern hospital.

DIRECTOR OF PERSONNEL—(a) 250-bed hospital; south. (b) 300-bed Michigan hospital. (c) Administrative assistant; 400-bed New England hospital.

ADMINISTRATOR—(a) 25-bed hospital; newly constructed, west. (b) 85-bed Ohio hospital. (c) 125-bed hospital, West Virginia; addition planned.

DIRECTORS, NURSING SERVICE—(a) To $7000. (b) Directors, school of nursing; nursing arts, science and clinical instructors. (c) Assistant directors—tuberculosis and psychiatric hospitals.

RECORD LIBRARIANS—(a) Chief; new large Ohio hospital; medical center. (b) 100-250 bed hospitals, Ohio, Virginia, Florida, Connecticut, Michigan, Pennsylvania, Texas; to $450.

TECHNICIANS—(a) Bio-Chemist; $450. (b) Registered laboratory technicians; $400-$500. (c) X-ray Technicians; laboratory and X-ray technicians; to $400.

EXECUTIVE HOUSEKEEPER—(a) New 100-bed Ohio hospital. (b) 300-bed hospital, Kentucky. (c) 200-bed Maryland hospital. (d) 150-bed hospital, Massachusetts. (e) 250-350 bed southern hospitals. (f) Hospital engineers; Salary open.

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Mr. Paul E. Loubris, Administrator, at his desk at Clearfield Hospital, Clearfield, Pa.
Clearfield Hospital (shown in inset) buys Boontonware from Fisher, Bruce & Co., Philadelphia.

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EXECUTIVE PERSONNEL—(a) Administrative assistant; California; 100-bed hospital; $5400. (b) Assistant administrator; 250-bed hospital near Chicago. (c) Administrative assistant; middle west; primary duties; supervision of hospital buildings; $5500. (d) Assistant administrator; east; large hospital; college degree plus 2 years hospital experience; to $8100. (e) Personnel and public relations director; West Coast; 450-bed hospital. (f) Personnel director; California; require college degree with major in industrial relations, psychology or business administration; to $7200. (g) Credit manager; California; 440-bed hospital. (h) Personnel director; east; man or woman; 250-bed hospital. (i) Personnel relations officer; southwest; 350-bed hospital; 650 employees. (j) Purchasing agent; middle west; 450-bed hospital; require good hospital purchasing experience. (k) Business manager; Florida; 75-bed hospital—new; duties: office management, accounting, some purchasing; to $5400.

PHARMACISTS—(a) M.W. Chief; handle all purchasing; 100-bed hospital; man or woman. (b) California; large hospital; near Los Angeles; $6500. (c) Chief; east; 400-bed hospital; $6500. (d) Staff; middle west; 425-bed hospital; excellent personnel policies; $6000. (e) Staff; east; 175-bed hospital near New York City. (f) Chief; southwest; new hospital completely air-conditioned; to $7000. (g) Staff; large teaching hospital, 7 in pharmacy; $5600.

DIRECTORS OF NURSES—(a) California; 50-bed hospital; no nursing school; 50 employees in department; $6000 plus housing. (b) Middle west; 200-bed hospital in city of 30,000; direct and administer nursing services concerned with patient care; to $6500. (c) South; 250-bed hospital in city of 85,000; 186 employees in department; $6000. (d) Northwest; 125-bed hospital in town of 15,000 close to large city; $5000 up. (d) East; 500-bed hospital; require good supervising experience; will have two assistants; $7000-$10,000, plus 4 room furnished apartment—television, etc. (e) East; 150-bed hospital in city of 60,000; no school of nursing; degree not required; to $6000.

INDIANA MEDICAL BUREAU
212 Bankers Trust Building
Indianapolis, Indiana

ADMINISTRATIVE — (1) Business Manager; 175-beds east. (2) Controller; 170-beds; east. (3) Administrator; 135-beds; midwest. (4) Administrator; 300-beds; midwest. (5) Administrator; 150-beds; midwest. (6) Administrative assistant; 600-beds; midwest. (7) Business manager-assistant administrator; no degree; south.

PHARMACISTS—(1) Chief; 250-beds; midwest. (2) Assistant chief; 123-beds; midwest.

PHYSICAL THERAPIST — Private office of noted orthopod; all professional fees including employment fee to be paid by employer; start $400.

MEDICAL TECHNICIANS—(1) Bacteriologist; 250-bed; midwest. (2) Chief; 25-beds and O.P. clinic $400-$500. (3) 66-beds east; registered or eligible; $300-$500. (4) Small eastern hospital $350.

INDIANA MEDICAL—*Continued*

X-RAY TECHNICIANS—(1) 85-beds; midwest $300. (2) 173-beds; east. (3) 200-beds; midwest; $250. (4) 25-beds; midwest; $250.

PHYSICIANS—(1) Resident; midwestern TB hospital. (2) Radiologist-Pathologist combination; small midwestern hospital. (3) Radiologist; 250-beds midwest. (4) Radiologist; 175-beds; east. (5) Psychiatrist; well known private midwestern hospital. (6) Staff physician; midwestern college. (7) Woman physician for school staff. (8) Pathologist; medium size eastern hospital. (9) Anesthesiologist; group and hospital; east; young. (10) Pathologist; 600-beds; midwest.

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(Continued on page 194)

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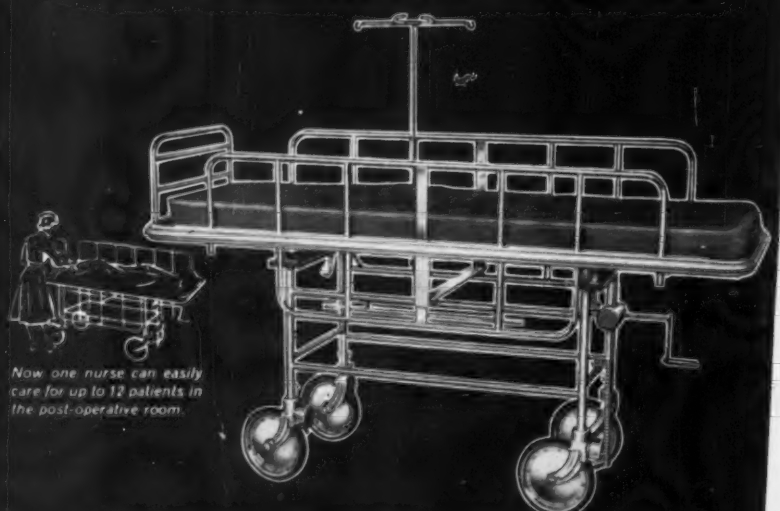

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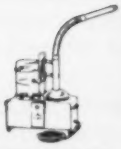

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(Continued on page 196)

SCHOOLS—SPECIAL INSTRUCTION

The BOSTON LYING-IN HOSPITAL offers to qualified registered nurses a six-months internship in maternity nursing. Clinical experience is offered in all phases. This includes antepartal clinics, delivery room, postpartum and diabetic unit, normal newborn, and premature nursery. Each nurse intern will have the opportunity to deliver a mother under supervision. An elective period will be spent in advanced experience in the area of choice. Room, laundry, food allowance and a stipend of $75 per month is granted. Rooms are provided in a graduate house. The registration fee is $20. For complete information write to Carolyn Davies R.N., Director of Nurses, Boston Lying-in Hospital, Boston, Massachusetts.

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GRADUATE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA offers a four month course in operating room technic and management to registered graduates of accredited schools of nursing. Registration fee $20.00. Full maintenance and $30.00 monthly cash allowance given. Apply to Director of Nursing Service, 1818 Lombard Street, Philadelphia 46, Pennsylvania.

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Missouri.

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The CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-months course in OBSTETRIC NURSING to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Illinois.

TOO LATE TO CLASSIFY

POSITIONS OPEN

ANESTHETIST — Nurse; excellent working conditions; $400.00 per month with annual increases of $25.00 per month to maximum of $500.00; three weeks vacation after one year; minimum of two weeks sick leave; usual employee benefits; Lexington is located in "The Heart of the Bluegrass" famous for horse racing and tobacco industries, home of University of Kentucky and Transylvania College. Apply Assistant Administrator, Good Samaritan Hospital, South Limestone Street, Lexington, Kentucky.

CLINICAL instructure in medical and surgical nursing; approved school of 50 students; all approved policies; B.A. required; M.A. desired. Write Director of Nursing, Danbury Hospital, Danbury, Connecticut.

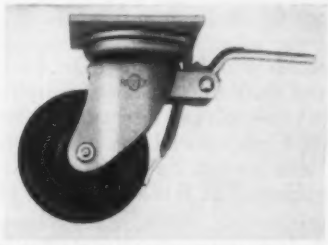
MISCELLANEOUS—Personnel Director, 3-11 House Supervisor, Operating Room and General Duty Nurses—Modern 278-bed general hospital in the beautiful and enchanting northwest; has nursing school diploma program; liberal personnel policies, 40 hour week, salary open. Apply Director of Nurses, Deaconness Hospital, Spokane, Washington.

Oxygen tent rolls safely on conductive Bassick casters

Here's another fine piece of hospital equipment that gets mobility from Bassick casters.

The Ohio Chemical and Surgical Equipment Company of Madison, Wisconsin puts this Model 25 Oxygen Tent on Bassick casters with conductive wheels that dissipate static charges.

These 4" Bassick casters roll smoothly and swivel easily, too. There's no sticking of wheel or swivel that might cause a sudden lurch or accident. And Bassick casters are noted for long wear, low maintenance. THE BASSICK COMPANY, Bridgeport 2, Conn. *In Canada:* Belleville, Ontario. 7.5



There are sizes and types of Bassick Truck Casters for all kinds of handling equipment—food carts, service trucks, laundry baskets, portable racks, etc. Casters with wheel and swivel locks, special stems for angle iron and tubing. Look to Bassick for casters.

Bassick

A DIVISION OF STEWART SW WARNER

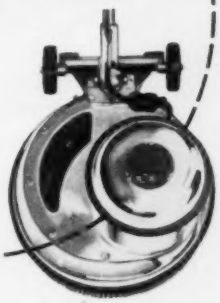
MAKING MORE KINDS OF CASTERS . . . MAKING CASTERS DO MORE

CLOCK 'EM AND SEE!

OFF-SET MOTOR WINS!

NOTHING OUTCLEANS A

KENT



More work done in *less* man-hours — at *less* cost — that's the kind of efficiency modern cleaning demands. That's why so many hospital, industrial and commercial users depend on the big Kent line to cut maintenance costs. Only Kent offers the cleaning development that makes floor maintenance completely easy — Kent's exclusive OFF-SET MOTOR design. Imperfect balance and sidewise pull of the brush make ordinary machines difficult to operate. Kent's exclusive, all-weight on brush OFF-SET MOTOR design counterbalances handle-weight . . . minimizes torque. Result: less fatigue, faster work, longer wear, fewer service problems. Get the facts . . . get the machine that cuts labor costs up to 18.9% over competitive makes!

Kent Off-set motor design floor machine — one of 24 such machines in use at 600-bed St. Luke's Hospital, N.Y.C. St. Luke's uses 54 Kent cleaning units, including Kent vacuum cleaners, for all types of wet and dry cleaning maintenance operations.

QUIET JUNIOR VACUUM CLEANER . . . ideal for all institutions.

Quiet operation and handling ease convinced St. Luke's Hospital . . . let us show you.

MAIL COUPON TODAY!

KENT COMPANY INC.
406 Canal Street, Rome, New York

Yes, I want to cut maintenance costs! Send full details on your line of ☐ floor machines ☐ vacuums.

Name .....
Firm Name .....
Address .....
City ..... State .....

Modern Gas Equipment in the kitchen of White Memorial Hospital

For cleanliness, efficiency and economy . . . White Memorial Hospital cooks with *GAS*

For cleanliness, efficiency and economy, Dr. Ruth Little, Director of Dietetic Service of the White Memorial Hospital in Los Angeles, chose a completely Gas-equipped kitchen. And for the most up-to-date equipment, Dr. Little insisted on a modern, built-in Gas range in addition to the latest automatically controlled kitchen appliances.

Modern Gas equipment at White Memorial Hospital includes:

2 Vulcan fryers	*1 Savory toaster*
2 Vulcan deck ovens	*1 Wolfe griddle*
4 Vulcan ranges	*2 Wolfe hot plates*
1 Western Holly built-in range	*1 Hobart dishwasher*
1 Middleby-Marshall revolving oven	*2 dry food tables*
3 steam cookers	*2 steam kettles*

For information on how you get faster, more efficient food service with modern Gas equipment, call your Gas Company's commercial specialist. He'll be glad to discuss the economy and outstanding results you get with Gas and modern Gas equipment.
American Gas Association.

WHAT'S NEW FOR HOSPITALS

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form opposite page 216. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Medical X-Ray Processor Produces Radiographs in 6 Minutes

The time needed to process Kodak Blue Brand Medical X-Ray Film is cut

to approximately six minutes with the Kodak X-omat Processor, Model M. The illustrated prototype of the radically new machine was shown at the Chicago meeting of the Radiological Society of North America on December 3, and the machine itself will be available during the latter part of 1957. It was designed for use in hospitals, clinics and radiologists' offices to deliver top quality radiographs, dry and ready for reading, in six minutes.

In operation, film is fed directly from the cassette into the processor. Small, motor-driven rollers arranged in offset positions transport the film through developing and fixing solutions and wash water. The roller action agitates the solutions to provide efficiency and uniformity of development. Recirculation and filtration of the processing solutions and an automatic system that meters in fresh solutions according to the actual length of the films processed assures day-to-day consistency.

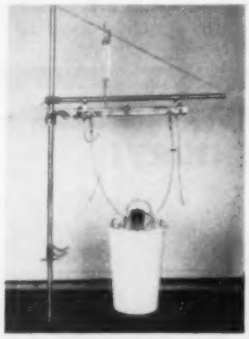
The over-all length of the new Model M is ten feet with the loading station of 22 inches being the only part that extends into the darkroom. Occupying less than 25 square feet of floor area, the new processor is so designed as to effect savings in water with minimum use of electric power, and chemical costs comparable to those of hand or other mechanical methods. Kodak Blue Brand X-Ray Film Sheets five by seven and larger can be fed into the processor in any sequence. The machine can process from 240 of the large 14 by 17 inch films to 1200 of the five by seven inch sheets each hour, according to the report. **Eastman Kodak Co., Rochester 4, N.Y.**

For more details circle #781 on mailing card.

Blood Dialyzer Employes Parallel Flow Principle

Demonstrated as clinically efficient and effective, the MacNeill-Collins Blood Dialyzer employs a unique design principle patterned after the parallel flow arrangement of natural capillaries. The blood flows in parallel streams through many cellophane tubes, flattened between nylon screens until the blood stream thickness is about 40 red cell diameters. The physiologic mechanisms employed have made it possible for Dr. Arthur E. MacNeill to develop many types of laboratory and clinical dialyzers which can operate with arterial pressure alone.

The Blood Dialyzer is a lightweight, compact, portable unit for bedside use. The entire unit can be autoclaved and stored and it does not have to be primed with blood. The Dialyzer does not



cause hemolysis, according to reports, and supplies urea clearance of 75 cc. at blood flow of 200 cc. per minute. It can operate on arterial pressure alone and holds only 20 liters of Dialyzing Solution. Clinical use indicates that the Dialyzer usually lowers patient's BUN 50 per cent in eight hours. **Warren E. Collins Inc., 555 Huntington Ave., Boston 15, Mass.**

For more details circle #782 on mailing card.

China-Cote Cup In Green Leaf Design

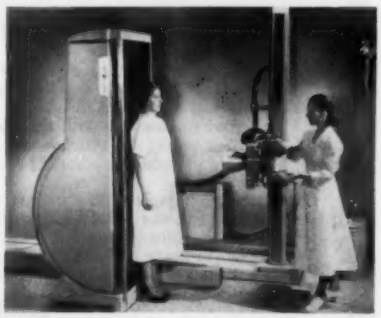
The green leaf design used on Lily paper cups for hospital use is now being made available in the Lily China-Cote cup. This plastic coated cup preserves the flavor when used with coffee, tea and other hot liquids. This addition to the line, and a new creamer just announced, complete the Lily line of disposable Matched Food Service for hospitals. The creamer has a tight-fitting lid with inset tab which is easily removed for use. **Lily-Tulip Cup Corp., 122 E. 42nd St., New York 17.**

For more details circle #783 on mailing card.

Diagnostic X-Ray Unit With Minimum Investment

The Patrician is a new type of x-ray unit offering virtually complete diagnostic medical x-ray service at minimum cost. Features of the new unit include a full-length 81 by 27 inch angulating table, a highly-maneuverable, independent tube stand, a double-focus rotating anode x-ray tube, a 200-milliampere, 100,000 volt full-wave transformer, and an automatic reciprocating Bucky grid to prevent scattered radiation from fogging the film. The table can be tilted throughout 105 degrees with three positive stops for Trendelenburg, horizontal or vertical, actuated by a foot-pedal release.

The precisely-counterbalanced screen can be moved throughout a full 41½ inches longitudinally and 10 inches transversely through the wide-range fluoroscopic carriage. Screen coverage of the patient during vertical examinations ranges from 16½ to 70 inches above the floor. The screen can be moved to and from the patient throughout a distance ranging from four to 18 inches from the table. Examination of the chest and abdomen are accomplished with the 12 by 12 inch fluoroscopic screen. The instantly responsive contoured shutter controls are shaped for ready manipulation



with the gloved hand. The screen is held in any desired position by friction locks. **General Electric X-Ray Dept., Milwaukee 1, Wis.**

For more details circle #784 on mailing card.

(Continued on page 200)

WHAT'S NEW

Powerful Plunger Effective for All Toilets

"Toilaflex" is a new, powerful plunger designed to fit toilets of all sizes and

shapes and to clear them quickly and effectively. The unusual design of the plunger permits it to bend around to fit into any toilet bowl trap. The suction-grooved lip forms an air-tight seal. With the over-sized air chamber, double the volume of compressed air is blasted directly at any obstruction in the toilet, breaking it up and washing it down. No air or water can escape, due to the special design of the new "Toilaflex." "Toilaflex" is marketed by the **Water Master Co., New Brunswick, N.J., through Stevens-Burt Co., New Brunswick, N. J.**

For more details circle #785 on mailing card.

Combine Dressing Economically Priced

The Surgipad Combine Dressing is now offered in the new five by nine inch size. Pre-wrapped, one per package, the Combine is low in price and efficient in use. It is especially effective on surgical procedures involving straight line incisions. Surgipad Combines are all absorbent and conform readily to body contours and around drain tubes. **Johnson & Johnson, Hospital Division, New Brunswick, N.J.**

For more details circle #786 on mailing card.

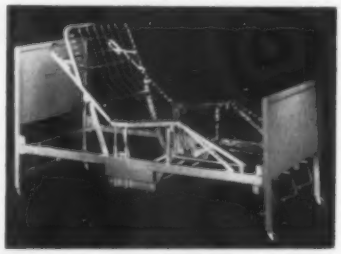
Fluro-Ethyl Solution is Topical Refrigerant

A non-flammable product for use as a topical refrigerant in plastic skin planing and to produce local anesthesia for minor surgical procedures is available in Gebauer's Fluro-Ethyl. The new Ethyl Chloride product is packaged in a metal aerosol container for ease of administration and use. Fluro-Ethyl is also effective as a local anesthetic for incision and electrocautery, as well as to produce painless intramuscular injections in children receiving Salk vaccine and other medication by injection. **The Gebauer Chemical Co., 9410 St. Catherine St., Cleveland 4, Ohio.**

For more details circle #787 on mailing card.

Adapto Bed Permits All Cardiac Positions

Adjustment to a full posture-chair sitting position, as well as to all other approved cardiac positions, is possible with the new Adapto Bed. The center spring



section may be raised separately for such positions as improved cardiac and reverse spinal. The Adapto spring has an independently adjustable head rest and foot section. It is also designed to meet all high-low requirements between convalescent and stretcher heights for convenient transfer of patients. It is easily raised to any position, even when occupied.

The improved design of the Adapto utilizes the entire length of the standard mattress for patient comfort, eliminating any depression break at the center. Adapto Bed Ends are designed in either full-panel or five-filler all steel construction with large, easy rolling rubber-tired casters. **Royal Metal Mfg. Co., 175 N. Michigan Ave., Chicago 1.**

For more details circle #788 on mailing card.

Hand Model Aneroid Has Separate Gauge

The gauge is separate from the cuff in the new Tycos Hand Model Aneroid. Inflating bulb and air release valve are built into the back of the gauge, with

the whole unit carefully balanced to fit comfortably in either the right or the left hand. The connecting tube is long enough to hold the gauge at the exact distance easiest for reading. A large thumb screw controls the release valve, producing a slow, uniform deflation of the cuff pressure. The gauge is connected to the cuff by a Luer lock fitting. **Taylor Instrument Companies, 95 Ames St., Rochester 1, N.Y.**

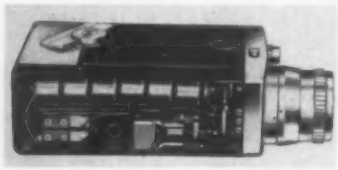
For more details circle #789 on mailing card.

(Continued on page 202)

WHAT'S NEW

"Electric Eye" Camera Sets Lens Automatically

A new development in motion picture cameras is introduced with the Model



200-EE Bell and Howell "Electric Eye" camera. Operating on the same principle as the human eye, the lens iris is automatically opened and closed to adjust to varying indoor or outdoor light intensities through a photo-electric cell or electric eye. No experience is needed to ensure properly exposed film with the new camera. There is even a warning flag which drops into the viewfinder to warn the operator when light is inadequate for proper exposure. If desired, the camera may be operated manually without the electric eye.

The camera has all of the excellent features of the standard Bell & Howell 16 mm motion picture camera in addition to the automatic lens adjustment.

Six tiny Mercury cells in the base of the camera energize the electric eye. The life of the batteries is stated as a minimum of one year and replacements are easily made when required. **Bell & Howell Co., 7100 McCormick Rd., Chicago 45.**

For more details circle #790 on mailing card.

Microscope Illuminator Gives High Intensity Light

A high intensity point source of illumination for microscopy, macro-photography and microphotography is available in the new Adams E & G Microscope Illuminator. Cool operation and long bulb life are assured through the built-in transformer. The unit operates on standard current. It can be focused from six inches to infinity and the built-in iris diaphragm controls the size of the light spot. The Illuminator has a heavy base for stability, yet the whole unit weighs only 4½ pounds. **Clay Adams, Inc., 141 E. 25th St., New York 10.**

For more details circle #791 on mailing card.

Plastic Dinnerware in Attractive Patterns

Decorated plastic institutional dinnerware is now available in several patterns. Designed by Joan Luntz, the new patterns in Arrowhead dinnerware were developed to enhance the appearance of food. The two new patterns illustrated are the Militaire, a narrow-rim design with pale pink batons on a base color of red; and the Ambassador, a narrow-rim leaf pattern in Tangerine, Sky Blue, Sunglow Yellow, Black and Mist Green. **International Molded Plastics, Inc., Arrowhead Div., 4387 E. 35th St., Cleveland 9, Ohio.**

For more details circle #792 on mailing card.

WHAT'S NEW

Electric Incubators for Laboratory Procedures

A temperature range from 37 to 110 degrees C. is offered in the new line of all-metal, electrically heated Cenco Incubators. Designd for a wide variety of laboratory applications, the incubators feature high precision, convenience of operation and safety. A tempered plate glass inner door, equipped with a latch, permits observation of activity without loss of heat. Rapid, constant heating is provided by nickel-chrome strip-type heating elements mounted between the

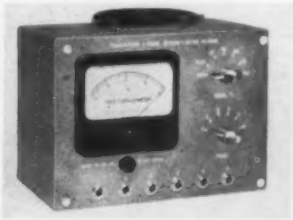
inner and outer walls and consistent temperatures are assured inside the units through the carefully calculated forced air circulation.

The incubators have high grade steel outer walls with three inches of glass wool composition insulation. They come in two sizes: No 46005 with three shelves and a total area of 376 square inches; and No. 46015 with four shelves and a total area of 920 square inches. **Central Scientific Co., 1700 Irving Park Rd., Chicago 13.**

For more details circle #793 on mailing card.

Multi-Range Thermometer Is Direct-Reading

The new Model 46 Tele-Thermometer is a direct-reading instrument with high accuracy and readability. It is a combination, six-channel, five-range Tele-Thermometer covering 30 to 110 degrees



F. with five overlapping ranges. The unit is completely portable, powered by a self-contained mercury battery. Any combination of YSICo's completely interchangeable themistor probe types can be used with the new Model 46, remotely or locally. **Yellow Springs Instrument Co., Inc., P. O. Box 106, Yellow Springs, Ohio.**

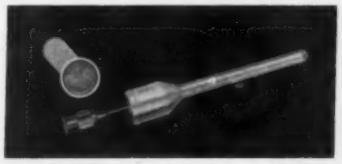
For more details circle #794 on mailing card.

(Continued on page 204)

Sterilon Needletainer Keeps Needle Sterile

A cleaned needle can be sterilized, and kept sterile indefinitely, in the new Sterilon Needletainer. Cleaned wet or dry needles are placed in Needletainers and the caps put on ready for sterilization. After the 30-minute sterilization period in the autoclave, the sterile needle will remain ready for use as long as the Needletainer cap is not removed. The needle can be attached to the syringe aseptically while still in the container or poured onto a sterile field, due to the sterile edge under the cap.

The nylon Needletainers may continue to be re-used as long as caps fit tightly. They are compact, unbreakable and are easy to store and carry. The shape pre-



vents the needle point from blunting against the bottom. **Sterilon Corp., 500 Northland Ave., Buffalo 11, N.Y.**

For more details circle #795 on mailing card.

WHAT'S NEW

Needle Holders Have Improved Grip

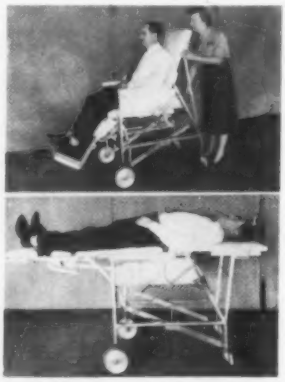
An improved "Bulldog" grip is incorporated into the jaws of the new Weck Needle Holder. The serrated areas of the jaws are hardened by a special process to give just the right combination of hardness to resist wear and assure a firm grip without injuring the needle. The serrations are an integral part of the jaws and are patterned so that the needle fits snugly into the grooves.

The jaw ends of the new needle holders have the new Glare-Proof finish developed by Weck for its stainless steel instruments. **Edward Weck & Co., Inc., 135 Johnson St., Brooklyn 1, N.Y.**

For more details circle #796 on mailing card.

Inval-Aid Chair Converts to Litter

Smooth and effortless change from full horizontal, as in a litter, to erect sitting with a vertical chair back, is possible with the new Inval-Aid Chair. A geared crank makes the change, with



the patient in horizontal position, from bed to chair simply and easily. The foot rest may be separately adjusted to a variety of positions.

The Inval-Aid Chair provides safe, comfortable transportation and rest for crippled patients and for others where a variation in body position is desirable. The new chair is carefully engineered and tested. Metal parts are of chrome steel and the foam rubber padding is covered. If desired, restraining straps are available. **The Hausted Mfg. Co., Medina, Ohio.**

For more details circle #797 on mailing card.

Institutional Packs for Three Jell-O Flavors

Black raspberry, black cherry and grape are the three new Jell-O flavors which are now available in institutional size packs. They bring to ten the number of Jell-O gelatin desserts now available in both 24 ounce and four and one-half pound boxes, twelve and six to the case, respectively. **General Foods, White Plains, N.Y.**

For more details circle #798 on mailing card.

Garbage Disposers in Heavy-Duty Models

Two new heavy duty models have been added to the line of Waste King commercial garbage disposers. The HV, powered by a 1½ h.p. motor, has a grinding

capacity of 1000 pounds per hour, for handling waste from large institutions. The HD is a ¾ h.p. unit designed to handle 575 pounds per hour. The new additions complete the Waste King line, making available units with grinder capacities ranging from 200 to 2000 pounds of food waste per hour.

Technical improvements in the two new models have been incorporated into the entire line of Waste King disposers. These include improved cone spray, redesigned overhead spray with squeeze-valve water control and a removable silverware trap. **Waste King Corp., 3301 Fruitland, Los Angeles 58, Calif.**

For more details circle #799 on mailing card.

Storage Drawer Fits Under Any Type Bed

The Nash Stow-a-Way Storage Drawer attaches to all type bed frames including wood or metal, bunk beds, box springs on wooden legs or cot-lounger types and fits all bed sizes from twin to three-quarter to full size. The all-metal drawer clamps to the bed frame to allow ease in cleaning while providing extra storage space.

The Stow-a-Way is available in two sizes and can be attached to the bed

frames without tools. The unit is finished in neutral suntan baked-on hammertone. It should be particularly useful for extra storage space in nurses' homes. **Nash Mfg. Co., 10024 Carnegie Ave., Cleveland 6, Ohio.**

For more details circle #800 on mailing card.

(Continued on page 206)

Traversing Vertical Blind in Fabric LouverDrape

A new vertical blind which is made of fabric and draws like a drapery is

offered in LouverDrape. It provides complete control of light, air and privacy and is manufactured in a variety of colorful DuPont fabrics from two to five inches wide. LouverDrapes close tightly, swivel open to any desired angle in a 180 degree radius for control of light and air, and draw completely open or closed.

The result of two years of research and engineering, LouverDrapes have tiny metal capsules which transport the blinds across the window on ball bearing wheels, keeping them under constant spring tension at top and bottom. The Cayton aluminum cornice channel provides a precise rotating control in any phase of the blinds drawn or open position and conceals and supports the simple working mechanism. Direction of the fabric louvers is controlled by a simple hand mechanism at the window. The blinds are fadeproof and have many uses in hospitals for efficient control of light, air and privacy and for attractive, home-like appearance. **Vertical Blinds Corp. of America, 1936 Pontius Ave., Los Angeles 25, Calif.**

For more details circle #801 on mailing card.

Drapery Fabric Controls Sun Glare

Translucent Cloth is the name of a new fireproof drapery material designed for the control of sun glare. Normal daylight illumination is permitted when the material is used in correct fullness and ventilation and outside viewing are combined with adequate privacy. The fabric may be washed or cleaned by any method, with any soap, detergent or chemical, without stretching or shrinking. It is certified as inherently fireproof by Underwriters Laboratories, according to the manufacturer, and it is exceptionally color fast and highly resistant to fume fade. **Edwin Raphael Co., Inc., Holland, Mich.**

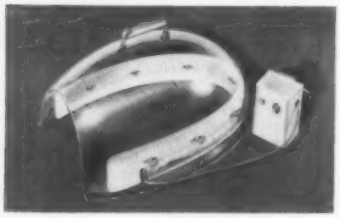
For more details circle #802 on mailing card.

(Continued on page 208)

WHAT'S NEW

New-Born Infant Warmer Offered in Aloe Thermadome

A safe, convenient and efficient method for keeping a new-born infant warm,



thus preventing loss of body heat in the first few hours after birth, is offered in the new Aloe Thermadome. Thermadome is constructed of one formed piece of ¼ inch Plexiglas in an elliptical shape for ideal heat convection. After a warming period, the temperature inside the Thermadome is approximately 20 degrees above the room temperature.

In the Thermadome the infant is completely safe as there is no heating element with which he can come in contact. Heat is provided by a removable, flat resistant element covered with insulating fiberglass, shielded by a ventilated polyethylene guard band. The Thermadome has been carefully designed to fit into the smallest standard bassinet and still allow ample room for the infant. Its transparent material provides full visibility from every angle. It is easy to handle and simple to operate by plugging into any standard electrical outlet. **A. S. Aloe Co., 1831 Olive St., St. Louis 3, Mo.**

For more details circle #803 on mailing card.

Jet Disposer for Food Waste

The principle of breaking up, pulverizing and liquefying food waste of all kinds is used in the improved FMC Jet Disposer. The liquefied waste, including bones and corn cobs, is discharged directly into the sewer line. Sorting and carting food waste is not necessary with the new equipment which is designed to prevent the possibility of jamming.

Large pieces of waste are first broken up in the dispenser by the twin breaker heads. The smaller sized particles enter the grinding rings through centrifugal force and the continuous cutting action reduces them to pulverized waste which is liquefied by the addition of water for discharge into the sewer line. The new model is designed for installation under the soiled dish table or in other convenient locations. A silver trap protects against damage to and loss of silverware. **Food Machinery and Chemical Corp., Kitchen Equipment Dept., Hoopeston, Ill.**

For more details circle #804 on mailing card.

Condensed Storage Space in Pharmaceutical Cabinet

Maximum storage area is provided in minimum floor space with the new McKesson Step-Saver Pharmaceutical Storage Unit. One two-foot unit contains the storage capacity of twelve feet of straight shelving, with pharmaceuticals immediately available. When the door is opened a wide range of pharmaceuticals is revealed. A second set of doors can be opened to make available a second set of shelves where bulk items and

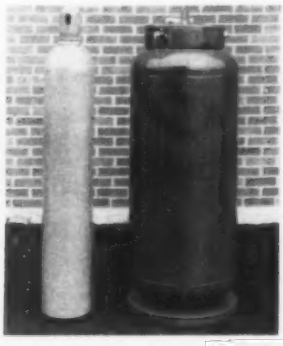
those less often called for can be stored. The unit measures two feet wide, 18 inches deep and seven feet in height. It is constructed to provide dustfree protection. **McKesson & Robbins, Inc., 155 E. 44th St., New York 17.**

For more details circle #805 on mailing card.

WHAT'S NEW

LC-3 Cylinder for Liquid Oxygen

The liquid equivalent of 3000 cubic feet of gaseous oxygen, or more than the contents of twelve standard 244 cubic foot cylinders, is contained in one of the new LC-3 liquid-oxygen cylinders only 58 inches high and 20 inches in diameter. The newly-developed cylinder is designed to answer the need of hospitals now employing manifolds of high-pressure cylinders to deliver oxygen to piping systems. The large capacity, com-



pactness and other features of the new LC-3 will effect savings of time, labor and money while providing a safer method of supplying oxygen. Twelve of the cylinders shown at the left in the illustration would be required to hold the quantity of oxygen held in the new LC-3 in liquid form. **Linde Air Products Co., 30 E. 42nd St., New York 17.**

For more details circle #806 on mailing card.

Magnetic Cassette Holder Protects X-Ray Users

Doctors, technicians and personnel are protected from x-ray exposure with the new Magnetic Cassette Holder. It is designed for use in the operating room, x-ray room, emergency room or other area of the hospital to eliminate the danger of irradiation exposure to hands and other body parts by film exposure x-rays. The new holder is versatile and adaptable for all needs. The base magnet can be applied to the "Bucky" tray and the cassette held and angled in two planes with only one dependent corner. Simple adjustments of the knurled screws permit absolute positioning of the cassette quickly, easily and securely.

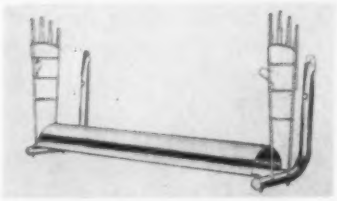
The Plymale Magnetic Cassette Holder consists of two powerful magnetic base holders, a base strip 1½ inches wide for use on plain operating or fracture tables, ledge type sterilizing and storing tray and two steel plates, and tube of liquid solder for mounting to back of non-ferrous cassettes. All pieces are heavily chrome plated and the entire unit can be sterilized in the autoclave. **Enco Mfg. Co., 4520 W. Fullerton Ave., Chicago 39.**

For more details circle #807 on mailing card.

(Continued on page 210)

Apron and Glove Holder of Heavily Chromed Steel

X-ray aprons and gloves are accommodated on the new No. 1040 Holder introduced in the Gaychrome Sturd-i-brite line manufactured especially for hospitals. When mounted on a wall, the 12½ inch high brackets protrude only 9½ inches. Heavy wire glove holders accommodate 15 inch long x-ray gloves with fingers and thumbs well separated and gauntlet held open for complete air circulation. Rounded edges provide maximum apron protection on the 32 inch long half-cylinder apron holder. The holder is sturdily constructed of heavily chromed steel. **The Gaychrome Manu-**



facturing Company, 1079 Southbridge, Worcester, Mass.

For more details circle #808 on mailing card.

WHAT'S NEW

Whirlpool Bath Has Recessed Motor and Pump

New principles of engineering design and manufacture are employed in

the new Scientific Precisioneered Whirlpool Bath. The motor and pump are mounted beneath the tank, adding to the safety of the unit since neither patient nor operator can come in contact with the pump or the motor. Full use of the available surface area of the bath can also be used. The pump is a heavy duty unit designed for long, trouble-free use.

Handles on top of the whirlpool control raising and lowering and direction of flow, while the On-Off switch mounted on the skirt of the tank is foot operated. A foot lever also controls the varying speed of the whirlpool action and drainage. The bath is designed and engineered for efficient operation and ease in handling. **Scientific Equip. Mfg. Corp., 838 Broadway, New York 3.**

For more details circle #809 on mailing card.

Stairmaster Safety Treads Have Red Lines

Double red lines at the safety tread edge of Stairmaster safety stair treads are designed as a visual safety device. This new development outlines the limits of the step, minimizing the possibility of stair accidents, especially for those with impaired vision or other handicaps. The new visibility line for safety is furnished without extra cost on extruded aluminum Stairmaster safety treads. It comes in a standard nine-inch width with anti-slip abrasive grit filler locked in V-shaped grooves. The safety treads are furnished with beveled ends in lengths as required and they are easily applied over any type of stair. **Wooster Products Inc., Wooster, Ohio.**

For more details circle #810 on mailing card.

Bucksco Book Cart Is Lightweight and Sturdy

A lightweight, easily maneuverable cart is offered in the new Bucksco unit for carrying books to the patient. It was developed at the request of auxiliaries and volunteer workers for a sturdy practical book cart requiring minimum maintenance. Book shelves on the sides tilt inward to keep books from sliding off while the cart is in motion. Magazine display racks on the ends have "open view" for quick reference to the publication wanted. A box for the librarian's card record file is placed in front of the push handle for quick reference.

The cart is mounted on rubber-tired swivel casters and can be easily turned

in its own length. It is designed to be readily handled between beds and is 21 inches wide, 41 inches long and 42 inches high. **Bucks County Enterprises, Inc., Quakertown, Pa.**

For more details circle #811 on mailing card.

WHAT'S NEW

Nurses' Gowns in Wrap-Around Style

Ample lap-over to prevent gapping and serve as a shadow panel is allowed

in the new Tomac Wrap-Around Nurse's Gown. The attractive princess styling fastens with three button adjustment for neat, comfortable fit for most sizes. Even when worn buttoned in the last adjustment the waist lap is full 9½ inches with 12 inches at the hemline. Freedom of movement and cool comfort are provided with the free action sleeve which has underarm insert for full coverage. Highly absorbent, long-wearing Tomac Sanforized Cloth is used for the new gown which retains its shape after laundering. It is available in white, misty green and jade green. **American Hospital Supply Corp., Evanston, Ill.**

For more details circle #812 on mailing card.

Motorized Unit for Tubular Wheelchairs

The Chair Boy is a completely self-contained motorized drive unit designed to fit most tubular wheelchairs. The

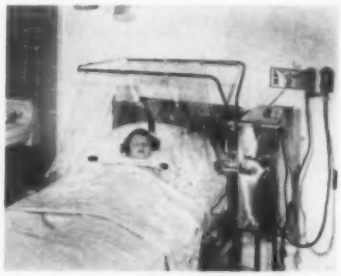
Unimatic single adjustable arm control provides two forward speeds, one reverse speed, steering and smooth braking. It is powered by two standard six-volt automotive batteries and will run ten to twenty miles between charges. It is designed to go up a ten degree ramp with ease. The Chair Boy is easily coupled or uncoupled in one minute and the coupling arrangement is engineered for safety and simplicity. **The General Medical Equipment Corp., Div. of Lumex, Inc., Valley Stream, N. Y.**

For more details circle #813 on mailing card.

(Continued on page 212)

Built-In Nebulizer in High Humidity Tent

Model No. 24300 is a new high humidity oxygen tent offering simple operation and high oxygen concentration when desired. It offers a built-in



nebulizing unit in a portable, space-saving, low-cost tent. Stainless steel is used for the outer cabinet and the inner ice chamber which has a capacity of 17 pounds. The tent can be supported by bed hooks on the headboard or used alongside the bed by means of an accessory stand adjustable to various bed heights.

The heavy-duty, fully transparent vinyl plastic canopy is supported on extensible hanger bars which can be folded down to save storage space when not in use. Either permanent or disposable type canopies are available. The tent can be operated to provide full, partial or no nebulization with maximum or decreased cooling. Nebulization is regulated by adjustment of a liquid throttling valve on the nebulizer. **National Cylinder Gas Co., 840 N. Michigan Ave., Chicago 11.**

For more details circle #814 on mailing card.

Automatic Slide Projector in Two Sizes

The new AO Executive Automatic two by two Slide Projector is offered in both 300 and 500 watt models. New features include modern design with the lower silhouette, a new optical system and automatic changer. Both the 300 and the 500 watt models have a five inch focal length lens with a speed of f 3.5

and an improved condensing system. The latter may be removed as a unit and opened like a book for easy cleaning.

The new AO Automatic Changer uses only one simple action to insert, return and refile slides and advance the tray. The new filtered shutter arrangement synchronized with the automatic changer reduces eye fatigue by eliminating complete blackout during slide changes. The illuminated numeral indicator on top of the projector shows the position of the tray in the changer. The trays are made of durable plastic and both models are equipped with the universal 40 slide tray. All controls are within fingertip reach of the operator. Cool operation is provided through the oversize motor driven fan and the new louver design. **American Optical Co., Chelsea, Mass.**

For more details circle #815 on mailing card.

Traction Machine for Vertical and Horizontal Use

The Levinthal Varitrak mounts on a wall bracket or foldaway table bracket for the administration of both vertical and horizontal cyclic and intermittent traction. The machine operates at three

cycles per minute and adjusts up to forces of 50 pounds. Controls allow the patient to start and stop the cycle when desired. A variety of accessories is available for the machine. **Levinthal Electronic Products, Inc., 2868 Fair Oaks Ave., Redwood City, Calif.**

For more details circle #816 on mailing card.

Electronic Air Cleaner Takes Less Space

The Trion Hev electronic air cleaner accommodates higher air velocities for greater cleaning efficiency yet matches more closely the face area of the heating and cooling coils for reduced space. The unit specified for 90 per cent efficiency is reduced ⅓ in size while the 95 per cent efficient unit is ¾ the size of a standard 90 per cent unit. All Hev units are equipped with a motorized moving washer and adhesive applicator for automatic maintenance. **Trion, Inc., 1000 Island Ave., McKees Rocks, Pa.**

For more details circle #817 on mailing card.

WHAT'S NEW

Toilet Tissue Dispenser Has Reserve Supply

Designed especially for institutional use, the new Reserv-A-Roll toilet tissue

dispenser stores three standard 1000-sheet rolls. When the empty roller is pushed down, a fresh roll of toilet tissue is automatically snapped into position, reducing maintenance time. The core is retained in the fixture for removal when reloading. Theft and vandalism are discouraged by a safety lock which also gives sanitary protection since rolls cannot fall on the floor. There is no waste because the rolls cannot spin. The Reserv-A-Roll dispenser is made of die-cast aluminum. **Reserv-A-Roll Co., 602 Sul Ross, Houston 6, Texas.**

For more details circle #818 on mailing card.

Spray Bandage Is Non-Occlusive

An antibiotic is incorporated into the new "breathing" spray bandage known as Spray Band. It is supplied in a push-button aerosol container for ease of application and provides a non-occlusive bandage for burns, minor cuts, abrasions and lacerations. The plastic film is described as non-irritating and well tolerated. **Schuco Industries, 75 Cliff St., New York 38.**

For more details circle #819 on mailing card.

Wireless Intercom Suppresses Circuit Noise

A new circuit developed for the Port-A-Phone Wireless Intercom suppresses noise in the electric wiring circuit so that the intercom will work in almost any situation. The portable intercom system requires no wiring or installation. It is easily carried to the location where it is to be used and plugged into the regular electrical outlet.

Another feature of the new Port-A-Phone is the improved Hush-O-Matic Silencer. This silences the unit when in the stand-by position to prevent disturbance or contact when communication between units is not required. **Feiler Engineering & Mfg. Co., 8026 N. Monticello Ave., Skokie, Ill.**

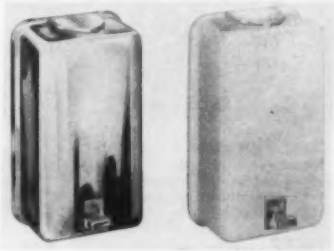
For more details circle #820 on mailing card.

(Continued on page 214)

Soap Dispenser Controls Soap Output

A new U-Set-It dispensing mechanism enables the Bobrick 33CP soap dispenser to release a controlled amount of powdered soap. A turn of a screwdriver in the completely concealed output set screw adjusts soap delivery to the desired amount, from a pinch to a handful. The new model will dispense even the coarsest type of soap powder with vegetable scrubbers.

A new self-scouring mechanism and press-down lever prevents messy soap accumulation and eliminates possibility of water reaching the soap. The container holds 34 fluid ounces and is constructed



of triple plated steel in polished chrome finish or white baked enamel. **Bobrick Dispensers, Inc., 1214 Nostrand Ave., Brooklyn 25, N.Y.**

For more details circle #821 on mailing card.

WHAT'S NEW

Instant Water Service By Light-Beam Control

When the light beam is broken by placing a glass or cup under the spout,

water pours instantaneously without pressure on levers or pedals in Electro-Fill Water Stations. Two new models are now available, the B-1260 Deck Type and the B-1265 Wall Type. The fully automatic water service unit saves time and also glass breakage. It is sanitary, fast and economical in operation, engineered for trouble-free performance. Complete sets of parts for the two new models are furnished, with instructions for easy installation. **T & S Brass & Bronze Works, Inc., 118 Seventh St., Garden City, L.I., N.Y.**

For more details circle #822 on mailing card.

Radiation Survey Meter Gives Direct Readings

Direct readings of x-ray, gamma and beta radiations over a full scale are now possible with the new Single Scale Logarithmic Radiation Survey Meter. Model 414 is a portable instrument with a large meter face and especially designed scale for easy reading. Minimum reading time and personal exposure in fields of high intensity radiation are achieved with the instrument. Reliable performance and accuracy throughout the entire

range are claimed with the new unique one-tube circuit used. **Atomic Instrument Co., 84 Massachusetts Ave., Cambridge 39, Mass.**

For more details circle #823 on mailing card.

Microfilm Camera Is Readily Portable

A motorized microfilm is now available which folds into a small case for carrying from one department or one building to another as needed. The Diebold Portable Microfilm Camera Model 9600 is a relatively inexpensive unit which can be easily operated by the average clerk. Copies are made in the fraction of a second by feeding the material to be photographed into the machine which has simple magazine loading. Microfilm copies are made at minimum cost and result in space saving in files and the safeguarding of copies of vital documents. All necessary controls are located on a simplified panel in the camera which is easily accessible to the operator.

For operation, the film magazine is dropped into place in the new camera, the lock snapped and the machine is ready to microfilm records, histories, reports, documents of various types and other material. The portable model is about the size of a portable typewriter case when closed in its compact carrying case. The stainless steel feed shelf folds

into the case automatically when the camera is closed and the entire camera folds into the case, which is an integral part of the unit. The camera is carefully made of highest quality material and workmanship and is designed to operate by plugging into any ordinary light outlet. The carrying case is made of rubber base synthetic material, designed to withstand normal wear and handling. **Flofilm Division, Diebold, Inc., Norwalk, Conn.**

For more details circle #824 on mailing card.

Non-Permanent Adhesive for Mounting Material

Delkote Tak is a new adhesive which can be used to mount various types of material on walls and other surfaces without damage. It is packed in a handy applicator tube and applied to signs, notices, announcements, holiday decorations, posters and other material for hanging on walls, woodwork, paint, tile or glass. The material adheres without marking or damaging the surface and is readily removed. Tak can be removed from any surface by rubbing with the finger. **Delkote, Inc., P.O. Box 1335, Wilmington 99, Del.**

For more details circle #825 on mailing card.

WHAT'S NEW

Pharmaceuticals

Sul-Spansion

Sul-Spansion is a new liquid adaptation of S.K.F.'s sustained release oral dosage form indicated for the treatment of respiratory, urinary and other infections due to susceptible microorganisms. Sul-Spansion incorporates a new drug, sulfaethylthiadiazole, and assures prolonged therapeutic blood and urine levels. **Smith Kline & French Laboratories, Philadelphia 1, Pa.**

For more details circle #826 on mailing card.

Tergemist

Tergemist is a potent aerosol solution designed for liquefaction of bronchial secretions in diseases characterized by thick, tenacious sputum. Tergemist combines a detergent, liquid and a solvent in one aerosol solution and is administered in an aerosol nebulizer attached to an air compressor or oxygen supply tank. It is supplied in bottles of 40, 250 and 500 cc. **Abbott Laboratories, North Chicago, Ill.**

For more details circle #827 on mailing card.

Magnacort

Magnacort and Neo-Magnacort, with neomycin for infection, are two new topical ointments indicated for atopic and contact dermatitis and other miscellaneous dermatoses. The water-soluble dermatologic corticoid properties facilitate penetration into inflammatory tissue and disperse slowly into fatty layers with consequent longer contact at the affected tissue site. Both are free of systemic and local side effects. **Pfizer Laboratories, 630 Flushing Ave., Brooklyn 6, N.Y.**

For more details circle #828 on mailing card.

Reditrin-T Capsules

Reditrin-T Capsules are indicated in the treatment of anemias due to a deficiency of iron as well as for pernicious anemia and certain macrocytic and megaloblastic anemias. A high potency hematinic with intrinsic factor and minerals, Reditrin-T Capsules provide effective therapy for all types of tractable anemias. **Merck, Sharp & Dohme, Div. of Merck & Co., Inc., Philadelphia 1, Pa.**

For more details circle #829 on mailing card.

Dorbantyl

Dorbantyl is a new evacuant indicated in the management and treatment of acute or chronic constipation in both adults and children. It is also effective after surgery and in general medicine. Dorbantyl provides triple laxative action of softening, bulking and expulsion of the stool by gentle peristaltic stimulation of the colon. **Schenley Laboratories, Inc., 350 Fifth Ave., New York 1.**

For more details circle #830 on mailing card.

(Continued on page 216)

V-Cillin-Sulfa Pediatric

V-Cillin-Sulfa Pediatric with a pleasant pineapple flavor combines Penicillin V with triple sulfas to provide a broader spectrum of antibacterial activity. The flavoring is incorporated with the medicament in dry granules and when reconstituted becomes 60 cc. of a bright yellow liquid. **Eli Lilly and Co., 740 S. Alabama St., Indianapolis 6, Ind.**

For more details circle #831 on mailing card.

T. H. & M.

T. H. & M. is a new non-narcotic and non-alcoholic cough syrup compounded of terpin hydrate and Methorate hydrobromide. The maple-flavored formula dulls the cough reflex, modifies and assists in the elimination of secretion and sooths inflamed surfaces. It is particularly designed for children and is supplied in pint bottles. **The Upjohn Company, Kalamazoo, Mich.**

For more details circle #832 on mailing card.

Vistabolic

Vistabolic is a new gerontotherapeutic preparation designed to help the geriatric patient bridge periods of stress. Vistabolic contains hydrocortisone, Stenediol and vitamin B12 and is available in both tablet and parenteral form. It is supplied in 30 tablet boxes and in 10 cc multiple dose vials. **Organon Inc., Orange, N.J.**

For more details circle #833 on mailing card.

WHAT'S NEW

Literature and Services

• The two systems available for **Judd Curtain Cubicles** are the subject of a new folder prepared by Stanley-Judd Div., Stanley Works, Wallingford, Conn. Both the Ceiling Track and Suspended Tubing systems are described and illustrated with construction design, typical layouts and complete specifications.
For more details circle #834 on mailing card.

• **"Sectional Cafeteria Counters"** is the title of a new catalog designed to demonstrate the flexibility of Southern cafeteria equipment. Offered by Southern Equipment Co., 4550 Gustine Ave., St. Louis 16, Mo., the two-color catalog shows the component parts of sectional counters and how they can be assembled to fill individual requirements.
For more details circle #835 on mailing card.

• Information on the new **Chicago Model 11 Gas, Steam or Electric-heated Flatwork Ironers** is contained in **Bulletin 2600** offered by Chicago Dryer Co., 2210 N. Pulaski Rd., Chicago 39.
For more details circle #836 on mailing card.

• The **Ranfac Surgical Catalog** contains detailed information on needles, syringes, adapters and other precision instruments offered by Randall Faichney Corp., 299 Marginal St., Boston 28, Mass. Catalog No. S-75 illustrates and describes each type of instrument available.
For more details circle #837 on mailing card.

• A most helpful 12 page booklet on **"Decorating"** is offered by Simmons Company, Merchandise Mart, Chicago 54. Four-color photographs on the front and back covers show rooms using Simmons Theme furniture and full colors are used to show the Theme colors available. Subjects covered in the informative brochure include "Do and Don't of Decorating," black and white sketches showing various possibilities in room arrangements, "How to Use Theme Colors," and "36 Color Schemes" which indicate furniture and upholstery color, wall color, accents, curtain and bed covers, with notes on the suggestions.
For more details circle #838 on mailing card.

• **Wilkinson Chutes** for soiled linen, rubbish or dust are described in a new folder issued by Wilkinson Chutes, Inc., 619 E. Tallmadge Ave., Akron 10, Ohio. Diagrammatic illustrations describe installations of chutes for each need.
For more details circle #839 on mailing card.

• Information on the line of immunizing agents prepared by The National Drug Co., 4663 Stenton Ave., Philadelphia 44, Pa. is contained in a new brochure, **"Biologicals by National."** A two-page chart for quick reference summarizes details of each agent with complete technical information found on other pages.
For more details circle #840 on mailing card.

• The complete line of exercise, health and therapeutic equipment is illustrated and described in **Catalog 10** released by Battle Creek Equipment Co., Battle Creek, Mich. Also included in the 36-page catalog is information on sun lamps.
For more details circle #841 on mailing card.

• A four-page supplement on **Hoffman Laundry Equipment** is available from U. S. Hoffman Machinery Corp., 105 Fourth Ave., New York 3. Washers, ironers, extractors and tumblers are described and illustrated in form M 107.
For more details circle #842 on mailing card.

• How various models of luminous hospital room lights can serve the patient and the doctor is told in a new booklet entitled, **"Complete Lighting for Hospital Rooms."** Photographs show typical hospital room installations and complete details and specifications on the lights are included. The booklet is available from Luminous Equipment Co., 1325 Webster St., Chicago 14.
For more details circle #843 on mailing card.

Supplier's News

United States Plywood Corp., 55 W. 44th St., New York 36, manufacturer of plastic and plywood products for building, announces the opening of a new branch operation at **1124 Seventeenth St., Santa Ana, Calif.,** headed by **Beryl Abbott.**

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Eastman Kodak Co.

782 Blood Dialyzer
Warren E. Collins Inc.

783 China-Cote Cup
Lilly-Tulip Cup Corp.

784 Diagnostic X-Ray Unit
General Electric Co.

785 "Tollafier" Plunger
Stevens Burt Co.

786 Surgipad Combine Dressing
Johnson & Johnson

787 Fluro-Ethyl
The Gebauer Chemical Co.

788 Adapto Bed
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789 Hand Model Aneroid
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842 Laundry Equipment Supplement
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FIREPROOF CHINA
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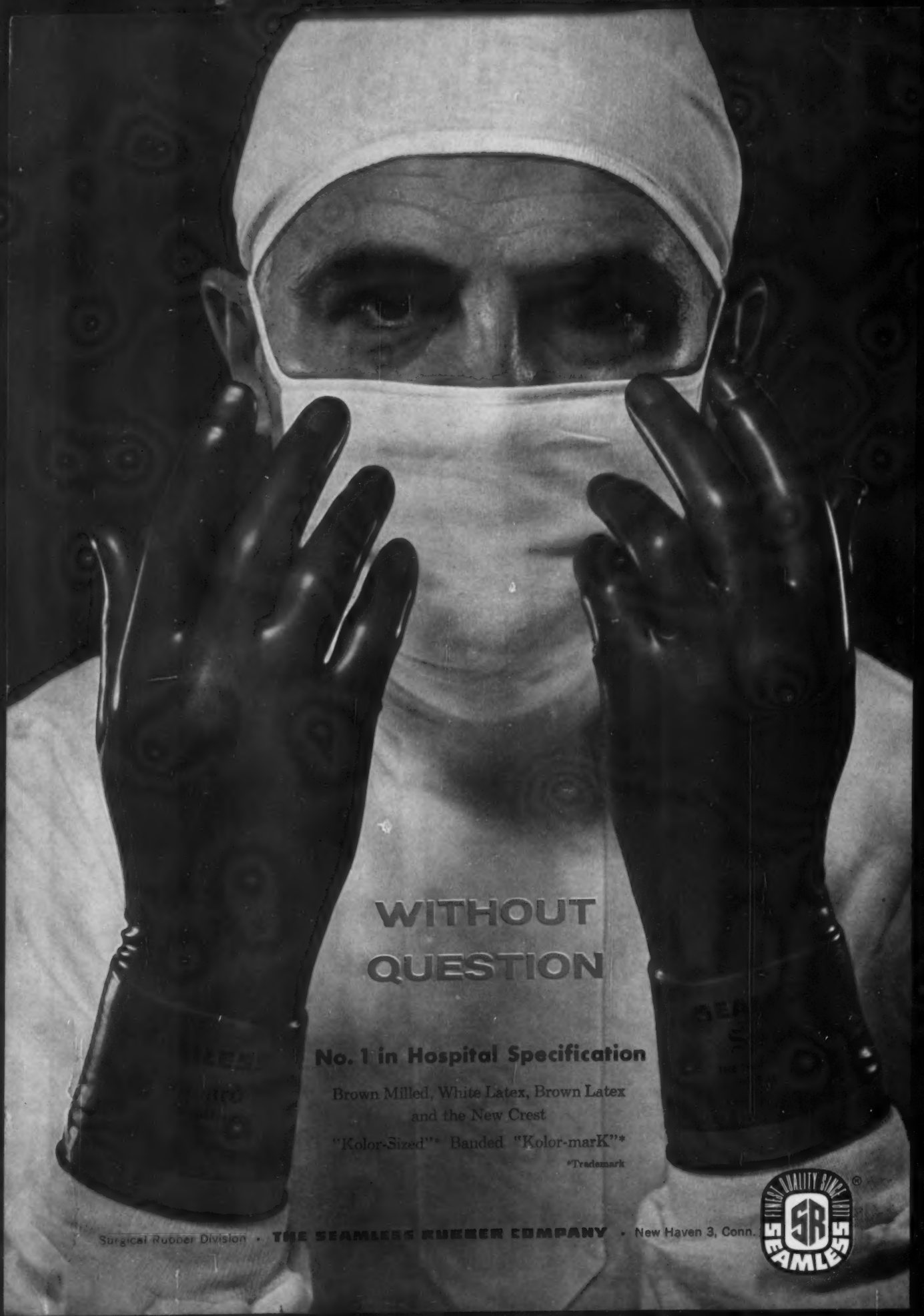
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